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ABSTRACT

This publication is a comprehensive record of testimony and exhibits presented by representatives of the Department of Health, Education, and Welfare (DHEW) to a subcommittee of the Committee on Appropriations of the U.S. House of Representatives during hearings on 1977 DHEW budget requests. Testifying for DHEW were F. David Mathews, Secretary of DHEW, John D. Young, Assistant Secretary (Comptroller), Stephen Kurzman, Assistant Secretary for Legislation, and Charles Miller, Deputy Assistant Secretary (Comptroller). Included in the record is an extensive report on overhead reimbursement to DHEW grantees and contractors that was prepared by the Surveys and Investigations Staff of the Committee on Appropriations. In addition, approximately two-thirds of the publication is devoted to a series of special reports on various DHEW programs that was prepared by DHEW for use by the Committee on Appropriations. These include reports on DHEW programs involving alcoholism, American Indians, cerebral palsy, day care, drug abuse, family planning, hearing and speech, juvenile delinquency, mental retardation, migrants, multiple sclerosis, muscular dystrophy, nursing homes, and older Americans. (JG)

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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

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PART 2

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Testimony of the Secretary

Special Reports

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE SUBCOMMITTEE APPROPRIATIONS FOR FISCAL YEAR 1977

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

THURSDAY, FEBRUARY 19, 1976.

OVERVIEW OF THE FISCAL YEAR 1977 BUDGET

WITNESSES

HON. F. DAVID MATHEWS, SECRETARY
JOHN D. YOUNG, ASSISTANT SECRETARY, COMPTROLLER
STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

Mr. FLOOD. The subcommittee will come to order.

We have the Department of Health, Eduction, and Welfare and the presentation will be made, of course, by the distinguished Dr. David Mathews, the Secretary of Health, Education, and Welfare.

I see we have biographical sketches of you, Mr. Secretary, and your colleagues which we will place in the record at this point.

[The sketch follows:]

DAVID MATHEWS, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, SEPTEMBER 1975

Dr. David Mathews was sworn in as the 11th Secretary of Health, Education, and Welfare by Chief Justice of the United States Warren E. Burger on August 8, 1975. He came to the Department from the University of Alabama where he had been president since 1969.

Dr. Mathews assumed the university presidency at age 33, the youngest man ever to hold that position. He was deeply involved with the university for more than 20 years as student, dean of men, history teacher, vice president, and president.

Secretary Mathews was born in Grove Hill, Ala., on December 6, 1935. Elected to Phi Beta Kappa as an Alabama undergraduate, he earned his doctorate in the history of American education from Columbia University in 1965. During 1959 and 1960, he served in the U.S. Army as an Infantry officer at Fort Benning, Ga.

As Secretary he heads a Department of 129,000 employees responsible for more than 350 programs and the expenditure of about one-third of the total Federal budget. At the beginning of his tenure, he established two major priorities: The dramatic improvement of Federal-State relations, and assistance to the disadvantaged in becoming self-reliant. He intends to work for the removal of statutory and regulatory barriers which inhibit State initiatives in the human resources area, and to bring the States into a close partnership with HEW in the administration of joint programs.

He views new Federal-State relationships as an essential condition to the effective delivery of services, and with that, improved opportunities for people to achieve self-reliance.

Dr. Mathews is married to the former May Chapman of Grove Hill. They have two daughters.

JOHN D. YOUNG

Position: Assistant Secretary, Comptroller, Department of Health, Education, and Welfare.

Birthplace and date: Cortland, N.Y.; February 5, 1919.

Education: Colgate University, 1941, A.B.; Syracuse University, 1943, M.S.; and American University, 1974, Ph. D.

Experience:

1973 to present: Assistant Secretary, Comptroller, Department of Health, Education, and Welfare.

1966–73: Deputy Associate Director, Energy and Science Division, and Director and Chief, Economics, Science and Technology Division, Office of Management and Budget.

1960–66: Assistant Administrator for Administration and Deputy Director of Administration; National Aeronautics and Space Administration.

1954–60: Principal, McKinsey & Co.

1951–54: Executive Officer and Executive Secretary, Office of Defense Mobilization.

Other experience:

1975: Member, supplemental security income study group.

1965: Member, President's Task Force on Cost Reduction.

1961: Adviser on organization of Peace Corps.

1953: Assistant to the chairman, Committee on Reorganization of Department of Defense.

1953: Staff member, President's Advisory Committee on Government Organization.

1942–45: U.S. Marine Corps.

Awards: William A. Jump Memorial Award for Outstanding Public Service; NASA Medal for Outstanding Leadership; OMB Exceptional Service Award; and National Civil Service League Award.

CHARLES MILLER II

Position: Deputy Assistant Secretary, Comptroller.

Birthplace and date: Philadelphia, Pa., November 22, 1923.

Education: BA, Princeton University 1947, major, history; MA, University of Pennsylvania 1948, major, political science.

Honors: Graduated cum laude from Princeton, 1947; elected to National Social Science Honor Society (Pi Gamma Mu) 1948; Superior Service Award, DHEW, 1964; quality salary increase, November 1968; Distinguished Service Award, April 1972.

Military service: 1943–46, U.S. Army, 2d lieutenant.

Experience:

April, 1974–present: Deputy Assistant Secretary, Comptroller.

1970–74: Deputy Assistant Secretary, Budget.

1969–70: Director, Division of Budget, Office of the Secretary, DHEW.

1968–69: Director, Office of Financial Management, HSMHA, DHEW.

1967–68: Director of Finance, Public Health Service, DHEW.

1965–67: Chief, Financial Management Branch, NIH, DHEW.

1960–65. Chief, Management Policy Branch, NIH, DHEW.

1958–60: Assistant to Assistant Secretary for Administration, DHEW.

1950–58: Management Analyst, Social Security Administration, DHEW.

Mr. Flood. You have some people with you, you would like us to meet, I suppose.

Secretary Mathews. Yes; I would, Mr. Chairman. I have Mr. Young, who is the Assistant Secretary, Comptroller; Mr. Miller, who is his deputy, and Mr. Stephen Kurzman, who is the Assistant Secretary for Legislation.

Mr. Flood. If and when you call upon them or they volunteer we would like a short biographical sketch of them.

Now, Mr. Secretary, I see you have a prepared statement. How do you want to handle it?

Secretary **MATHEWS**. I would prefer to read my statement, if that meets with your approval, Mr. Chairman.

Mr. **FLOOD**. Well, it's your show.

Secretary **MATHEWS**. All right, sir.

It is certainly a pleasure to make this appearance before the committee. You have quite a responsibility before you in overseeing the budget of this Department. I can certainly appreciate the size of your task.

OVERALL SIZE OF THE BUDGET

The budget I will talk to you about today is $140 billion in outlays—up $12 billion from last year.

Your committee will be considering $44.2 billion in budget authority, $2.1 billion more than the 1976 appropriation.

Our $140 billion constitutes roughly 35 percent of the total Federal budget—compared with about 34 percent last year.

Of this amount about 97 percent is, to all intents and purposes, not controllable through annual appropriations. In this category we include such outlays as social security benefits which are spent from trust funds, and cash welfare payments which you do appropriate annually, but which are determined by amounts due to beneficiaries and are not really subject to your choice or ours.

This is not to say that nothing can be done about spending levels for these programs.

PROPOSED LEGISLATION

Of major importance in the President's budget are legislative recommendations which would affect outlays in the so-called uncontrollable programs. Key examples are legislation to:

—Provide greater short- and long-run financial soundness for the social security trust funds;

—Restrain increases in medical costs;

—Provide coverage of catastrophic costs of health services covered under medicare;

—Increase cost sharing for medicare beneficiaries;

—Standardize requirements under Aid to Families with Dependent Children to make them more equitable and less costly nationwide.

There are a number of further examples. If your committee wishes, we would be glad to provide you with a complete list. I would like to make the point, however, that, if the Department's budget were allowed to grow unconstrained by any cost-saving legislation—even if there were no new initiatives—it would be $3.4 billion higher than the budget that is before the Congress now.

BLOCK GRANTS

There is one other major area I would like to discuss before turning to the items that are of direct concern to your committee. You are already quite familiar, I'm certain, with the fact that one of the major proposals that we are making is to consolidate, through legislation, 45 of the Department's programs in separate block grants for education, health, and social services.

These consolidations will:

—Give States and local governments greater flexibility in determining funding priorities;

—Simplify program administration at both Federal and State levels;
—Eliminate existing inequities in Federal funding;
—Focus Federal resources on the poorest and most disadvantaged; and
—Eliminate required State matching.

The Financial Assistance for Health Care Act consolidates 16 Public Health Service, medicaid and developmental disabilities programs into a new $10 billion health service grant to the States. Legislation would provide for a $10.5 billion authorization level in fiscal year 1978 and $11.0 billion in fiscal year 1979.

A new $3.3 billion Financial Assistance for Elementary and Seconary Education Act State block grant consolidates 27 elementary and secondary, vocational, adult, handicapped, and library programs.

Existing social services legislation, title XX of the Social Security Act, would be modified by the proposed Financial Assistance for Community Services Act. A $2.5 billion authorization is being proposed. Required State matching would be eliminated along with many of the current title XX restrictions.

We are, however, asking your committee to appropriate funds for the programs contained in these block grants on a traditional line item basis. In other words, we are not asking you to wait to appropriate the funds until the legislation has been determined. This is a change from past practice and I know it is a welcome one for your committee.

HEALTH

Health services

Our request for funding for health services programs, most of which would be folded into the block grant, is generally at the same level as the President's original fiscal year 1976 budget request, but about $500 million less than the amount Congress has appropriated. Examples of the programs for which this is true include community health centers, family planning, migrant health, and emergency medical services. For most of the $500 million reduction we have proposed rescissions on which we testified yesterday.

We are again recommending that no funds be appropriated for comprehensive health grants to States—the so-called 314(d) grants, and that funding for community mental health centers be limited to continuation costs only.

Two programs offer major exceptions to a status quo budget for health services:

1. National Health Service Corps

The President's 1977 request for the National Health Service Corps will place 676 health professionals in 330 underserved health care areas.

—This is an increase of 14 percent in the number of health professionals and 22 percent in the number of sites staffed in 1976.
—Approximately 820,000 people, 22 percent over 1976, will have health care available through this program.
—By 1977, 150 communities which have received Federal support in the past will be self-sufficient and will continue projects started

under the National Health Service Corps without additional Federal assistance.

—$3.9 million will be returned to the Federal Treasury in 1977 as a result of fees collected from patients provided care at National Health Service Corps sites.

2. Public Health Service hospitals

As I look at the health care system in this country, it is impossible for me to defend continued operation of our small network of Federal hospitals to provide medical services to a very limited clientele.

The President's 1977 budget proposes to serve the hospital's primary beneficiaries through the free standing PHS clinics and by contracting with medical facilities in their communities. We will transmit to the Congress legislation necessary to tranfer to community use or to close the eight existing PHS hospitals.

The hospitals are located in Boston, Staten Island, Baltimore, Norfolk, New Orleans, Galveston, San Francisco, and Seattle. There are approximately 223,006 eligible primary beneficiaries.

The Department proposes to close these facilities because:

—Only 69 percent of the hospitals' capacity will be used in fiscal year 1976 (even if the hospitals were scheduled to remain open in 1977);

—Only 53 percent of the total number of persons being served by the hospitals in fiscal year 1976 will be primary beneficiaries;

—The hospitals are located in major metropolitan areas where adequate community facilities are available to care for current PHS hospital beneficiaries;

—At least five of the hospitals are in areas with an excess of hospital beds for community needs. Continued operation of PHS facilities in such areas increases hospital costs;

—For the hospitals to remain operational, substantial capital investment would have to be made to enable them to meet modern community hospital standards.

Preventive health

The venereal disease, immunization, rat control, and lead-based paint programs would be funded in the block grant. We are asking your committee to appropriate the same amounts for these programs as were requested in the President's revised 1976 budget.

Two major programs considered by this committee would not be placed in the block grant. We are requesting increases for both.

1. Occupational health

We are recommending a $37 million funding level. This will permit the National Institute for Occupational Safety and Health (NIOSH) to recommend to the Department of Labor, during each of the next 2 years, criteria on 24 hazardous substances that impinge on the health of 1.7 million people in the workplace. This compares with 18 criteria which will be completed in 1976.

The budget will also allow intensified efforts to identify and prevent cancer of occupational origin through field studies and epidemiologic investigations in 46 high-risk industries, as compared with 37 in 1976.

2. Laboratory Improvement

We will provide at $4 million increase for the Laboratory Improvement program in the National Center for Disease Control. This would permit us to increase the number of laboratories participating in proficiency testing programs from 1700 to 3200, thereby increasing the reliability of diagnostic tests performed in the Nation's clinical laboratories. This will result in a saving of both dollars and unnecessary hospitalization.

Biomedical research

We are requesting more than $2.1 billion for Biomedical Research. We are asking that the Committee reduce the Cancer and Heart Institutes below fiscal year 1976 appropriation levels, but for each of the other institutes, we are asking an amount either equivalent to or above the fiscal year 1976 appropriation. These latter funds are directed toward redressing the imbalance of resources among institutes. Special emphasis will be devoted to emerging research areas such as immunology, aging, and environmental health.

A major thrust of the President's request for NIH is the funding of the initial construction phase of a new ambulatory care facility, and the modernization of the outmoded Clinical Center. The Center's outpatient program will expand from approximately 35,000 visits in 1975 to 195,000 by 1980. This growth will permit a more economical means of carrying out clinical research, and a more effective evaluation of the long-term benefits of the research findings being applied in the clinical research program.

Alcoholism, drug abuse, and mental health administration

The community programs in mental health and alcoholism would be folded into the block grant at the President's 1976 revised budget level.

With respect to the Department's drug abuse programs, the President's 1977 budget includes an increase of $25.4 million over the revised estimate for 1976 to implement the recommendations of the White Paper on Drug Abuse.

7,000 additional treatment slots will be established in communities, bringing to 102,000 the number of slots supported by Federal funds.

New demonstration projects for the treatment of amphetamine and barbiturate abuses will be undertaken.

A major patient followup will be initiated to assess the long-term effectiveness of drug abuse treatment.

Health professions education

With the exception of nursing support, the programs contained under this heading remain, after 2 years, unauthorized in substantive legislation and funded under the continuing resolution. New legislation must, therefore, be passed before your Committee can appropriate funds. Consequently, our budget is based on our legislative proposals. These proposals focus on redressing the imbalances in the specialty and geographic distribution of health professionals. This is a shift from prior emphasis on increasing the supply of health care providers by expanding enrollments. That goal has been met as evidenced by the increase in medical school enrollments of 57 percent between 1969 and 1975.

Of the total amount requested in 1977:

Approximately 80,000 students will be supported by a $120 million program for capitation assistance to schools of medicine, osteopathy, and dentistry. Schools must agree to:

Set aside 20 percent of their 1978–79 entering class for applicants who will practice in underserved areas;

Establish an identifiable training program in primary care for undergraduate medical students; and

Have 40 percent of their residency positions in primary care family medicine, general internal medicine, general pediatrics, and general medicine by the end of the 1978–79 school year.

Approximately 4,600 students who agree to serve in the Public Health Service, in other Federal health service, or in a health manpower shortage area will be supported by a $35 million Health Service Scholarship program.

$128 million will support special projects, including:

Family medicine and primary care residency programs,

Physician extenders and dental assistants projects,

Programs to expand the enrollment of disadvantaged students.

Nearly 560 nurse practitioners and 350 graduate nurses will be supported by a $36 million program for nursing education. This is a major increase in the number trained at these academic levels in 1976.

Professional Standards Review Organizations

The 1977 level will provide for the development of PSRO's in all of the 203 PSRO areas nationwide. Of these, approximately 120 will actually be performing review of hospital admissions in fiscal year 1977.

It is estimated that 3 million admissions of medicare and medicaid patients—or 27 percent of the total—will be reviewed by PSRO's in 1977.

Based upon past experience with PSRO-type review organizations, it is estimated that $150 million will be saved through reduction in unnecessary hospital utilization as a result of these PSRO reviews.

In addition to the $62 million provided in this account for PSRO's, an additional $27 million will be obligated from medicare and medicaid monies to pay for the actual costs of review. This is the result of the recent enactment of amendments to the Social Security Act.

Saint Elizabeths Hospital

We have before this committee a fiscal year 1976 supplemental request for funds for St. Elizabeths Hospital, and significant increases in the 1977 budget. Both of these requests are designed to assist in regaining accreditation for the hospital. The supplemental request will permit an increase of 104 positions and correction of fire and safety hazards identified by the accreditation survey.

The budget proposes continued Federal control of the hospital in 1977.

The Department is now working with the District of Columbia to arrive at a mutually agreeable date for transfer of the hospital to District control. As soon as agreement is reached, legislation will be introduced to:

—Set the transfer date;

—Gradually reduce Federal support for operation of the hospital after transfer, and

—Authorize $75 million for construction and/or renovation of mental health facilities at St. Elizabeths Hospital, taking into consideration the mental health facilities needs and resources of the District of Columbia.

EDUCATION

Elementary and secondary education

Most of the elementary and secondary education programs are included in the block grant. The funding requests before you under existing authority generally ask that you appropriate funds for these programs at the revised fiscal year 1976 level.

We are asking for $90 million in fiscal year 1977 for bilingual education—which is not included in the block grant—an $8 million reduction below the fiscal year 1976 level.

This would provide for support for more than 360 classroom demonstrations in which some 185,000 bilingual children would participate.

Education for the handicapped

All of the education for the handicapped programs would be included in the block grant except for deaf-blind centers. Our $236 million appropriation request provides the same dollar level as the 1976 appropriation and would permit us to serve 425,000 handicapped children under the State grant program.

Impact aid

We are still asking the Congress to reform the impact aid program. We recognize the pitfalls, but we feel we must keep this issue before you. We are asking that you appropriate all of the funds that are needed to take care of the so-called impact of Federal activities for "A" children—children whose parents both live and work on Federal property—and for certain other special provisions such as payments to the Defense Department for schools they operate on Federal property.

But we are again asking the Congress not to appropriate funds for "B" children—those whose parents work but do not live on Federal property and for the children whose parents live in low-rent public housing. With respect to public housing, I would particularly caution the committee that this new funding category, which we strongly believe does not represent a federally imposed burden, has the potential for growing to a $200 million item in the budget.

I want to assure you, Mr. Chairman, that we are submitting legislation to the Congress which would change substantive law as a back up to the appropriation language we are asking your committee to adopt.

Emergency school aid

We are asking for $250 million for emergency school aid in fiscal year 1977, an $8 million increase over the enacted fiscal year 1976 appropriation. With these funds, we will be able to assist local school districts in meeting problems related to desegregation and maintaining educational quality during the desegregation process. Of the total appropriation request, $35 million—including the entire $8 million increase—will be directed toward civil rights training and advisory services under title IV of the Civil Rights Act.

Higher education

Legislative authority for virtually all of the programs under this appropriation expires at the end of June 1976. However, the budget contains appropriation requests based on the Administration's recommended legislation.

1. Student assistance

Our 1977 budget request for higher education would maintain the Administration's policy of concentrating Federal resources on student aid. This policy places priority on assuring that all qualified students have funds to obtain at least a low-cost postsecondary education.

The basic grant program will be the principal form of Federal aid, providing a floor of assistance to needy students. The estimate of $1.1 billion is based on the estimate of what it would cost to fully fund all 4 years of college for eligible students.

Additional State assistance to students will be stimulated through continued incentive grants to States to encourage scholarship support.

The guaranteed student loan and college work-study programs will be continued.

Duplicative student assistance programs are proposed for repeal, in particular the supplemental educational opportunity grant and national direct student loan programs. These programs are duplicative of either the basic grant or guaranteed student loan programs.

2. Other higher education

We will continue the priority we have given to the program to strengthen developing institutions—which is focused on institutions enrolling a large percentage of minority students. We are asking for $110 million, virtually the full legislative authority.

Generally, for the remaining higher education programs, we are asking either that they be reduced or terminated. In the latter category, the principal terminations would be veterans' cost of instruction, aid to land-grant colleges, and university community services.

Educational research—National Institute of Education

We are asking for a $20 million increase for the National Institute of Education directed toward the following purposes:

—Disseminating the results of research and development.

—Conducting research into why children fail to acquire basic skills such as reading and math—and how to correct these deficiencies.

—Focusing on problems of educational equity, including multicultural and bilingual education, and women.

—Improving the contribution education makes to the abilities of people to choose, enter, and progress in work.

SOCIAL SECURITY

The major actions we are asking the Congress to take with respect to Social Security are included in our proposed legislation to which

I referred earlier. These include measures to strengthen the fiscal soundness of the trust funds and to provide greater catastrophic protection for Medicare beneficiaries, while at the same time asking these beneficiaries to pick up a larger share of their initial hospital and physician costs.

Under the supplemental security income program, we are estimating that Federal benefit payments will increase from $4.5 billion in 1976 to $5.2 billion in 1977. This will permit State supplementary funds to decrease from $1.3 to $1.2 billion.

The total number of beneficiaries will increase from approximately 4.6 to 5.2 million.

I know this committee has expressed a great deal of interest in the administrative soundness of the supplemental security income system. I think we are on the right track.

We expect the following management improvements in the supplemental security income program:

—Case error rates in SSI are projected to drop from 24.4 percent in 1975 to 15 percent by the end of fiscal year 1977.
—Over 4.7 million redeterminations of eligibility will be conducted in fiscal year 1977 to increase the accuracy of benefit payments.
—Current claims and payment systems will be strengthened.
—Recommendations of the study group on SSI will be evaluated and acted upon to improve program administration.

In addition to these management improvements specifically directed toward the SSI program, the Social Security Administration is also developing a master plan to greatly improve and modernize the Social Security Administration's automated systems.

PUBLIC ASSISTANCE

The public assistance category in the budget is largely made up of three items: Cash assistance—or aid to families with dependent children—medicaid, and social services. The budget that is before you is based on the State estimates received in August. We are asking your committee to appropriate $18,022 million, an increase of slightly over $1 billion over the revised 1976 request.

Our request includes a fiscal year 1976 supplemental which is now before you of approximately $1.9 billion. Over $500 million of the supplemental request would restore funds borrowed in 1975 from the 1976 appropriation.

What these figures show essentially are some slight reductions in numbers of recipients from 1976 to 1977, with an average benefit increase of from $70 to $76. Our legislative proposals include medicaid under the health block grant and the current social services program—title XX—and the State and local training programs under the social services block grant.

HUMAN DEVELOPMENT

For the programs administered by our Office of Human Development, the fiscal year 1977 budget proposes $1.6 billion, approximately $95 million below 1976. In the Head Start program, we would continue to serve roughly 350,000 children, at least 10 percent of whom are handicapped children as required by statute.

We are requesting $720 million for basic State grants in the rehabilitation services program, the same amount appropriated for 1976. In total, 1,459,000 persons will be served under the State grant program of which over 650,000 would be severely disabled. And, we expect that nearly 340,000 persons will be rehabilitated in 1977.

In addition to rehabilitation services funding in the human development account, another $145 million in social security funding provides rehabilitation services for an additional 193,000 severely disabled persons.

Under the Older Americans Act, we are asking to continue the two major programs of community services and nutrition at the same levels as in recent years. The $88 million request in 1977 for nutrition for the aged would support a $150 million program level serving approximately 290,000 daily meals 5 days a week. The community services program will maintain support of the existing 462 area agencies on aging—about 7 million older Americans are served through these agencies.

HEW EMPLOYMENT

We are asking your committee to authorize positions under existing legislation. If the block grant legislation and the proposals to close or transfer PHS hospitals are adopted by the Congress, we will be able to reduce employment by roughly 6,500 slots.

The proposals before you include the following major items:

—The conversion of 6,000 social security employees from 2-year term positions to permanent positions and 2,000 additional positions to reduce overtime and support more field training.

—150 new positions for the Office for Civil Rights.

—50 new positions for the Office of General Counsel which would be located in the regional offices and would be devoted entirely to processing claims from social security applicants. We are reducing departmental overhead by an equivalent 50 positions as an offset against these positions.

I would like to close with a few comments on the subject of the financial integrity of our programs. The appropriations committees in both the House and the Senate have expressed considerable concern over our ability to assure that the Department's funds are being used both with effectiveness and propriety. Both the House and Senate reports on the first supplemental appropriation requested a special report on this subject which we are submitting. In this context, I want to assure you of my own personal attention to these matters.

As you know, with the Congress' help, we are taking specific steps to increase our central surveillance through a new Office of Investigations, which is reporting directly to the Under Secretary. Among other efforts, we have requested increased staff to monitor our student aid and medicaid programs. The Social Security Administration is engaged in vigorous efforts to improve the systems upon which accurate and equitable SSI payments must be based.

You have my assurance, Mr. Chairman, that I will support and monitor these efforts.

That concludes my testimony, Mr. Chairman. I would be delighted to answer any questions that you and your colleagues have.

Mr. **Flood**. We are delighted to have you here. This is your first appearance, Mr. Secretary, before the committee.

At the same time we would like you to know we have a new member of our subcommittee, a distinguished gentleman from the great Commonwealth of Massachusetts, Mr. Early. We are pleased to welcome him to the subcommittee.

Mr. **Early**. Thank you, Mr. Chairman.

SUMMARY TABLES

Mr. **Flood**. We will insert in the record at this point a number of charts and tables which HEW has prepared for the committee.

[The material follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Budgeted Permanent Employment, Fiscal Years 1976 and 1977

Agency	1976 Authorized Positions	1976 Estimated Man-Years	1976 On Duty Dec. 31	1976 Anticipated June 30	1977 Positions Requested	1977 Estimated Man-Years	1977 Anticipated On Duty, Sept. 30
Department of Health, Education, and Welfare - Summary	137,923	141,766	131,678	135,003	140,328	143,536	135,498
Public Health Service:							
Food and Drug Administration	6,631	6,543	6,643	6,432	6,750	6,47C	6,501
Health Services Administration	15,527	15,331	15,597	15,061	15,587	15,092	15,120
Center for Disease Control	3,659	3,563	3,606	3,549	3,700	3,569	3,589
National Institutes of Health	10,660	10,821	10,690	10,324	10,660	10,660	10,324
Alcohol, Drug Abuse, and Mental Health Administration	5,701	5,474	5,418	5,530	5,670	5,515	5,500
Health Resources Administration	2,082	1,950	1,921	2,019	2,081	2,024	2,019
Office of Assistant Secretary for Health	929	951	962	901	933	903	901
Subtotal, PHS	45,189	44,633	44,837	43,816	45,381	44,233	43,954
Education Division:							
Office of Education	3,099	2,873	2,755	2,995	3,237	3,084	3,136
National Institute of Education	340	340	299	330	340	335	330
Office of Assistant Secretary for Education	261	235	211	253	247	240	240
Subtotal, Education	3,700	3,448	3,265	3,578	3,824	3,659	3,706
Social and Rehabilitation Service	2,159	1,858	1,722	1,950	2,159	2,058	2,092
Social Security Administration	79,293	84,696	75,061	78,359	81,243	86,158	78,309
Office of Human Development	1,504	1,433	1,386	1,433	1,512	1,441	1,441
Departmental Management	6,078	5,698	5,407	5,867	6,209	5,987	5,996

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Budgeted Permanent Employment, Fiscal Years 1976 and 1977

Appropriation	1976 Authorized Positions	1976 Estimated Man-Years	1976 On Duty Dec. 31	1976 Anticipated June 30	1977 Positions Requested	1977 Estimated Man-Years	1977 Anticipated On Duty, Sept. 30
Food and Drug Administration (FDA)							
Appropriation...........	6,265	6,177	6,277	6,077	6,384	6,104	6,146
Reimbursement...........	20	20	20	19	20	20	19
Service and Supply Fund.	111	111	111	108	111	111	108
Certification...........	235	235	235	228	235	235	228
Total, FDA..........	6,631	6,543	6,643	6,432	6,750	6,470	6,501
Health Services Administration (HSA)							
Appropriation - HSA.....	7,266	7,228	7,407	7,048	7,395	7,111	7,173
Reimbursements - HSA....	35	31	34	34	36	35	35
Service and Supply Fund.	143	138	139	139	143	139	139
Consolidated Working Fund.................	42	37	41	41	42	41	41
Appalachian Regional Commission............	14	13	13	13	14	13	13
Bureau of Prisons.......	112	100	108	108	72	89	70
Subtotal, HS........	7,612	7,547	7,708	7,383	7,702	7,428	7,471
Appropriation - IHS.....	7,861	7,730	7,835	7,642	7,831	7,610	7,595
Reimbursements - IHS....	54	54	54	54	54	54	54
Subtotal, IHS.......	7,915	7,784	7,889	7,678	7,885	7,664	7,649
Total, HSA........	15,527	15,331	15,597	15,061	15,587	15,092	15,120
Center for Disease Control (CDC)							
Appropriation...........	3,514	3,422	3,465	3,408	3,551	3,426	3,444
Reimbursements..........	144	140	140	140	148	142	144
Trust Fund..............	1	1	1	1	1	1	1
Total, CDC........	3,659	3,563	3,606	3,549	3,700	3,569	3,589

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Budgeted Permanent Employment, Fiscal Years 1976 and 1977

NATIONAL INSTITUTES OF HEALTH

Appropriation	1976 Authorized Positions	1976 Estimated Man-Years	1976 On Duty Dec. 31	1976 Anticipated June 30	1977 Positions Requested	1977 Estimated Man-Years	1977 Anticipated On Duty, Sept. 30
National Institutes of Health:							
National Cancer Institute.......	1,887	1,887	1,894	1,830	1,887	1,887	1,830
National Heart and Lung Institute......................	704	710	681	683	704	700	683
National Institute of Dental Research......................	269	285	278	261	269	272	261
National Institute of Arthritis, Metabolism and Digestive Diseases......................	560	556	545	543	560	555	543
National Institute of Neurological and Communicative Disorders and Stroke...........	511	509	517	496	511	506	496
National Institute of Allergy and Infectious Diseases........	587	616	574	569	587	582	569
National Institute of General Medical Sciences..............	153	156	149	148	153	150	148
National Institute of Child Health and Human Development...	354	362	369	343	354	354	343
National Institute on Aging.....	173	193	175	168	173	173	168
National Eye Institute..........	141	142	118	137	141	131	137

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Budget Permanent Employment, Fiscal Years 1976 and 1977

NATIONAL INSTITUTES OF HEALTH - Continued

	1976				1977		
Appropriation	Authorized Positions	Estimated Man-Years	On Duty Dec. 31	Anticipated June 30	Positions Requested	Estimated Man-Years	Anticipated On Duty, Sept. 30
National Institute of Environmental Health Sciences.	238	251	233	231	238	249	231
Research Resources.............	74	74	65	72	74	74	72
John E. Fogarty International Center for Advanced Study in the Health Sciences...........	50	49	45	48	50	49	48
National Library of Medicine...	468	491	462	454	468	487	454
Office of the Director.........	547	519	574	531	547	519	531
NIH Management Fund............	3,183	3,292	3,208	3,071	3,183	3,183	3,071
Service and Supply Fund........	761	729	803	739	761	729	739
Total, National Institutes of Health.............	10,660	10,821	10,690	10,324	10,660	10,660	10,324

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Budgeted Permanent Employment, Fiscal Years 1976 and 1977

	1976				1977		
Appropriation	Authorized Positions	Estimated Man-Years	On Duty Dec. 31	Anticipated June 30	Positions Requested	Estimated Man-Years	Anticipated On Duty, Sept. 30
Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)							
Appropriation - ADAMHA.....	1,559	1,554	1,613	1,512	1,528	1,497	1,482
Appropriation - SEH........	4,132	3,910	3,795	4,008	4,132	4,008	4,008
Working Capital Fund.......	10	10	10	10	10	10	10
Total, ADAMHA......	5,701	5,474	5,418	5,530	5,670	5,515	5,500
Health Resources Administration (HRA)							
Appropriation..............	2,048	1,916	1,887	1,985	2,022	1,974	1,961
Reimbursements.............	16	16	16	16	41	32	40
Consolidated Working Fund..	18	18	18	18	18	18	18
Total, HRA.........	2,082	1,950	1,921	2,019	2,081	2,024	2,019
Office of Assistant Secretary for Health (OASH)							
Appropriation..............	629	668	680	610	633	612	610
Service and Supply Fund....	260	247	247	252	260	252	252
Consolidated Working Fund..	40	36	35	39	40	39	39
Total OASH.........	929	951	962	901	933	903	901
PHS AGENCY TOTAL...	45,189	44,633	44,837	43,816	45,381	44,233	43,954

T-3

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Budgeted Permanent Employment, Fiscal Years 1976 and 1977

Office of Education

	1976				1977		
Appropriation	Authorized Positions	Estimated Manyears	On Duty Dec. 31	Anticipated June 30	Positions Requested	Estimated Manyears	Anticipated on Duty Sept. 30
Salaries and Expenses	3,099	2,873	2,755	2,995	3,237	3,084	3,136

NOTE: Includes Indian Education and allocation accounts.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
National Institute of Education
Budgeted Permanent Employment, Fiscal Years 1976 and 1977

Appropriation	1976				1977		
	Authorized Positions	Estimated Man-Years	On Duty Dec. 31	Anticipated June 30	Positions Requested	Estimated Man-Years	Anticipated on Duty, Sept. 30
National Institute of Education	340	340	299	330	340	335	330

T-3

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
EDUCATION DIVISION
OFFICE OF THE ASSISTANT SECRETARY FOR EDUCATION

Budgeted Permanent Employment, Fiscal Years 1976 and 1977

Appropriation	1976				1977		
	Authorized Positions	Estimated Manyears	On Duty Dec. 31	Anticipated June 30	Positions Requested	Estimated Manyears	Anticipated on Duty Sept. 30
Salaries and Expenses:							
Office of the Assistant Secretary for Education....	52	47	42	50	50	48	48
Fund for the Improvement of Postsecondary Education....	18	17	16	18	18	18	18
National Center for Education Statistics.......	191	171	153	185	179	174	174
Total................	261	235	211	253	247	240	240

T-3

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Employment Detail, Fiscal Years 1976 and 1977

Social and Rehabilitation Service

	1976				1977		
Appropriation	Authorized Positions	Estimated Man-Years	On Duty Dec. 31	Anticipated June 30	Positions Requested	Estimated Man-Years	Anticipated on Duty Sept. 30
Work Incentives Allocation to Department of Labor	[255]	[246]	[246]	[246]	[255]	[246]	[246]
Program Administration	2,124	1,823	1,687	1,915	2,124	2,023	2,057
Cuban Refugee Assistance	35	35	35	35	35	35	35
Total, SRS	2,159	1,858	1,722	1,950	2,159	2,058	2,092

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Budget Permanent Employment, Fiscal Years 1976 and 1977

Social Security Administration

Appropriation	1976 Authorized Positions	1976 Estimated Man-Years	1976 On Duty Dec. 31	1976 Anticipated June 30	1977 Positions Requested	1977 Estimated Man-Years	1977 Anticipated on Duty, Sept. 30
Salaries and Expenses..........	77,514	82,596	73,416	76,580	79,499	84,432	76,565
Advances and Reimbursements....	870	857	736	870	1,471	1,415	1,471
Special Benefits for Disabled Coal Miners 2/.................	871	1,198	871	871	242	275	242
D.O.L. Reimbursable...........	38	45	38	38	31	36	31
Total, Social Security Administration.................	79,293 3/	84,696 1/	75,061 4/	78,359 1	81,243 3/	86,158 1/	78,309 3/

1/ Excludes overtime equivalent as follows:
   1976: 6,493 man-years
   1977: 4,600 man-years

2/ Excludes 81 positions and 78 man-years in 1976 and 73 positions and 74 man-years in 1977 for Office of the General Counsel, HEW.

3/ Excludes 500 positions in 1976 and 1977 for the Worker-Trainee Opportunity Program.

4/ Excludes 414 positions for the Worker-Trainee Opportunity Program.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Budgeted Permanent Employment, Fiscal Years 1976 and 1977

Office of Human Development

	1976				1977		
Appropriation	Authorized Positions	Estimated Manyears	On Duty Dec. 31	Anticipated June 30	Positions Requested	Estimated Manyears	Anticipated on Duty Sept. 30
Human Development	1,504	1,433	1,386	1,433	1,512	1,441	1,441

T-3

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Budgeted Permanent Employment, Fiscal Years 1976 and 1977

Departmental Management

Appropriation	1976 Authorized Positions	1976 Estimated Man Years	1976 On-duty Dec. 31	1976 Anticipated June 30	1977 Positions Requested	1977 Estimated Man Years	1977 Anticipated on-duty Sept. 30
General Departmental Management.....	3232	3059	2950	3122	3267	3165	3152
General Departmental Management Reimburseables....................	173	156	158	167	165	160	159
Working Capital Fund................	1692	1573	1476	1606	1653	1597	1566
Consolidated Working Fund...........	19	14	11	10	15	14	10
Civil Rights........................	907	844	761	907	1054	999	1054
Consumer Affairs....................	55	52	51	55	55	52	55
Total, Departmental Management......	6078	5698	5407	5867	6209	5987	5996

Amounts in FY 1977 Budget for Which Legislative Authority has Expired or is Due to Expire on June 30, 1976

Summary

	Unauthorized Amount in FY 1977 Budget
Health Services Administration........................	$ 49,629,000
Center for Disease Control............................	33,710,000
National Institutes of Health.........................	105,106,000
Alcohol, Drug Abuse and Mental Health Administration..	263,200,000
Health Resources Administration.......................	283,000,000
Total, Health...........................	734,645,000
Education Division....................................	1,801,971,000
Assistant Secretary for Human Development.............	776,500,000
Total, DHEW.............................	3,313,116,000

T-2

Amounts in FY 1977 Budget for which Legislative Authority has expired or is Due to Expire on June 30, 1976

	Unauthorized Amount in FY 1977 Budget
Health Services Administration	
Health services:	
National health service corps, Sec. 329, PHS Act.....	$ 24,529,000
Home health services, Sec. 602, P.L. 94-63...........	---
Emergency medical services, Title XII, PHS Act.......	25,100,000
Total, HSA.........................	49,629,000
Center for Disease Control	
Preventive health services:	
Veneral diseases, Sec. 318(d)(2), PHS Act..............	19,840,000
Immunization, Sec. 317(d)(1),(2), and (3), PHS Act....	4,960,000
Rat control, Sec. 317(d)(3), PHS Act..................	5,410,000
Lead-Based Paint Poisoning Prevention Act of 1973....	3,500,000
Total, CDC.........................	33,710,000
National Institutes of Health	
Title IV, Part I, National Research Service Awards...	105,106,000
National Cancer Institute...........................	(18,163,000)
National Heart and Lung Institute....................	(12,335,000)
National Institute of Dental Research................	(3,131,000)
National Institute of Arthritis, Metabolism, and Digestive Diseases................................	(5,883,000)
National Institute of Neurological and Communicative Disorders and Stroke.............................	(4,719,000)
National Institute of Allergy and Infectious Diseases	(5,070,000)
National Institute of General Medical Sciences.......	(40,851,000)
National Institute of Child Health and Human Development.....................................	(6,916,000)
National Institute on Aging..........................	(1,590,000)
National Eye Institute...............................	(3,840,000)
National Institute of Environmental Health Sciences..	(2,243,000)
Research Resources..................................	(365,000)

T-2

	Unauthorized Amount in FY 1977 Budget
Alcohol, Drug Abuse, and Mental Health Administration	
Alcohol, drug abuse, and mental health	
General mental health training, Sec. 472(d), PHS Act..	$ 5,510,000
Drug abuse:	
Training, Sec. 472(d), PHS Act........................	500,000
Community programs:	
Project grants and contracts, Sec. 410, Drug Abuse Office and Treatment Act............................	145,285,000
Formula grants, Sec. 409, Drug Abuse and Treatment Act..	35,000,000
Alcoholism:	
Training, Sec. 472(d), PHS Act........................	400,000
Community programs:	
Project grants and contracts, Sec. 311, Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act................................	30,905,000
Formula grants, Sec. 301, Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitaiton Act....	45,600,000
Total, ADAMHA..............	263,200,000
Health Resources Administration	
Health resources	
Health manpower (except nursing), Title VII, PHS Act.....	283,000,000
D.C. medical manpower assistance, Medical and Dental Manpower Act of D.C....................................	—
Total, HRA..................	283,000,000
Total, Health............................	734,645,000

T-2

	Unauthorized Amount in FY 1977 Budget
Office of Education	
Elementary and secondary education	
Education broadcasting facilities (Communications Act of 1934 Title III Part IV)	$ 7,000,000
Higher education	
1. Student assistance: Higher Education Act (HEA)	
Basic opportunity grants (HEA, Title IV-A-1)	1,100,000,000
Work-study (HEA, Title IV-C)	250,000,000
Subsidized insured loans:	
Interest on insured loans (HEA, Title IV-B and Emergency Insured Student Loan Act)	75,000,000
Incentive grants for state scholarships (HEA, Title IV-A-3)	44,000,000
2. Special programs for the disadvantaged (HEA, Title A-4)	60,331,000
3. Institutional assistance:	
Strengthening developing institutions (HEA, Title III)	110,000,000
Language training and area studies:	
Centers, fellowships and research (National Defense Education Act Title VI)	8,640,000
Coöperative education (HEA, Title IV-D)	8,000,000
Subtotal, Higher Education	1,655,971,000
Special projects and training:	
Teacher corps (Part B-1, EPDA)	37,500,000
Total, Office of Education	1,700,471,000
National Institute of Education	
National Institute of Education, Sec. 405, General Education Provisions Act	90,000,000
Assistant Secretary for Education	
Fund for the Improvement of Postsecondary Education, Sec. 404, General Education Provisions Act	11,500,000
Total, Education Division	1,801,971,000

T-2

	Unauthorized Amount in FY 1977 Budget
Assistant Secretary for Human Development	
Human Development:	
Rehabilitation Services and Facilities	
Rehabilitation Act of 1973............................	$776,000,000
Salaries and Expenses:	
Architectural and Transportation Barriers Compliance Board,Sec. 502, Rehabilitation Services Act of 1973...	300,000
Office of Handicapped Individuals, Sec. 405, Rehabilitation Services Act of 1973........................	200,000
Total, ASHD..	776,500,000

T-10

Funds in the 1977 Budget for Proposed Legislation

Appropriation	1977 Budget Authority (Obligations)	1977 Outlays
Health Bloc Grant		
Financial Assistance for Health Care.........	$ 10,001,500,000	$ 9,001,200,000
Preventive health services..................	-33,710,000	-15,000,000
Alcohol, drug abuse and mental health......	-216,331,000	-30,832,000
Health resources...........................	-96,300,000	-55,000,000
Public assistance..........................	-9,292,000,000	-9,292,000,000
Salaries and expenses (SRS)................	-24,250,000	-22,000,000
Human development..........................	-55,225,000	-24,727,000
Education Bloc Grant		
Financial Assistance for Elementary and Secondary Education..........................	3,300,000,000	294,000,000
Elementary and secondary education.........	-2,072,888,000	-197,000,000
Education for the handicapped..............	-220,375,000	-34,546,000
Occupational, vocational and adult education..................................	-67,500,000	-9,450,000
Library resources..........................	-137,330,000	-26,100,000
Other Legislative Proposals:		
HSA		
Health services............................	(-18,797,000)	---
ADAMHA		
Construction and renovation Saint Elizabeths Hospital.................	75,000,000	8,250,000
SRS		
Public assistance..........................	-216,000,000	-216,000,000
Work incentives............................	-55,000,000	-55,000,000
SSA		
Federal Funds:		
Payments to social security trust funds...	-143,000,000	-143,000,000
Trust Finds:		
Old age and survivors trust fund...........	2,031,000,000 (- 790,000,000)	-790,000,000
Disability insurance trust fund............	1,451,000,000 (-36,000,000)	-36,000,000
Hospital insurance trust fund..............	-10,000,000 (2,130,000,000)	2,130,000,000
Supplementary medical insurance trust fund.	--- (-101,000,000)	-101,000,000
Departmental Management		
Allied services............................	20,000,000	5,000,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Appropriations for Which Budget Requests
Funds to Remain Available Beyond the Budget Year
(Includes direct construction)

Agency and Account	Program	Length of Availability	Authority
Food and Drug Administration.....	Construction, $3,125,000	Until expended	Annual appropriation act
Indian health facilities.........	Construction, $40,345,000	Until expended	Annual appropriation act
National Institutes of Health:			
Buildings and facilities.......	Direct construction projects	Until expended	Annual appropriation act
Health Resources Administration:			
Medical facilities guarantee and loan fund................	Interest subsidies, $31,000,000	Until expended	Public Health Service Act, Section 1622 and annual appropriation act

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Appropriations for Which Budget Requests Funds to Remain Available Beyond the Budget Year
(Includes direct construction)

Agency and Account	Program	Length of Availability	Authority
National Institutes of Health:			
Buildings and Facilities.................	Direct construction projects	Until expended	Annual appropriation act

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Appropriations for Which Budget Requests
Funds to Remain Available Beyond the Budget Year
(Includes direct construction)

Agency and Account	Program	Length of Availability	Authority
Office of Education:			
Elementary and Secondary Education......	Educational broadcasting facilities	Until expended	Part IV of Title III of the Communications Act of 1934
School Assistance in Federally Affected Areas..............	Construction	Until expended	Public Law 81-815 - School Construction in Areas Affected by Federal Activities
Higher Education.......................	Work-study	2 years	Title IV, Part C of the Higher Education Act of 1965
Higher Education.......................	Basic educational opportunity grants--Program funds	2 years	Title IV, Part A-1 of the Higher Education Act of 1965
Higher Education.......................	Subsidized insured loans (guaranteed student loans)	Until expended	Emergency Insured Student Loan Act of 1969
Higher Education.......................	Subsidized construction loans	Until expended	Title VII, Part C of the Higher Education Act of 1965
Higher Education.......................	Incentive Grants for State scholarships	2 years	Title IV, Part A-3 of Higher Education Act of 1965

Agency and Account	Program	Length of Availability	Authority
Educational Activities Overseas (Special Foreign Currency Program)............................	Grants to American institutions	Until expended	Agriculture Trade Development and Assistance Act of 1954; Sec. 104,(b)(2) & (3), Special Foreign Currency. Mutual Educational and Cultural Exchange Act of 1961. P.L. 87-256; Sec. 102(b)(6) & 105(d)
Student Loan Insurance Fund.............	All	Until expended	Title IV, Part B of the Higher Education Act of 1965
Higher Education Facilities Loan and Insurance Fund.................	All	Until expended	Title VII, Part C of the Higher Education Act of 1965
Occupational, Vocational and Adult Education.........................	Innovation	50 percent of total until expended and 50 percent for two years	Part D of the Vocational Education Act

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Appropriations for Which Budget Requests
Funds to Remain Available Beyond the Budget Year
(Includes direct construction)

Agency and Account	Program	Length of Availability	Authority
Gallaudet College	Direct Construction, $2,255,000	Until Expended	Act of June 18, 1954 (68 Stat; 265) and annual appropriation
Howard University	Direct Construction, $10,000,000	Until Expended	Act to Incorporate Howard University

T-1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Appropriations for Which Budget Requests Funds to Remain Available Beyond the Budget Year
(Includes Direct Construction)

Agency and Account	Program	Length of Availability	Authority
Social and Rehabilitation Services:			
Rehabilitation Service	Grants for the Developmentally Disabled	June 30, 1978	Part C, Section 132(a)(3) Developmentally Disabilities Services and Facilities Construction Act. P.L. 91-517.

DEPARTMENT OF HEALTH, EDUCATION, AND WELARE

Fiscal Year 1976

Social Security Administration

Agency and Account	Program	Length of Availability
Social Security Administration:		
Limitation on Construction (Trust Fund)	Construction of Headquarters, Program Centers, and District Office facilities as authorized by Section 201(g)(1) of the Social Security Act.	Until expended

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Student Aid and Training Programs

Summary

	1977		
	New	Continuing	Total
Office of Education.............	1,312,390,000	542,869,000	1,855,259,000
National Institute of Health.....	11,616,000	96,885,000	108,501,000
Other Public Health Service	76,800,000	84,900,000	161,700,000
Total.........................	1,400,806,000	724,654,000	2,125,460,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Education

Student Aid and Training Grants 1977

	New [1]	Continuing [1]	Total
Education for the Handicapped:			
Special Education and Manpower Development:			
Fellowships	$ 5,600,000	$ 5,500,000	$ 11,100,000
Training grants	---	---	---
Other grants in Aid	---	---	---
Higher Education:			
Fulbright-Hays fellowships	1,180,000	---	1,180,000
NDEA-VI fellowships	2,150,000	---	2,150,000
Subtotal, fellowships	3,330,000	---	3,330,000
Fulbright-Hays Training grants	180,000	---	180,000
Direct Loans:			
Teacher cancellations[2]	---	11,920,000	11,920,000
Loan volume	(126,213,000)	(126,214,000)	(252,427,000)
Subsidized insured loans:[3]			
Interest on insured loans	55,430,000	245,300,000	300,730,000
Death and disability[2]	---	5,797,000	5,797,000
Special allowance	20,050,000	154,072,000	174,122,000
Loan volume subsidized	(1,255,000,000)	(6,216,000,000)	(7,492,000,000)
Total payment	75,480,000	405,169,000	480,649,000
Subtotal, loans	75,480,000	405,169,000	480,649,000
Basic educational opportunity grants[3]	1,100,000,000	---	1,100,000,000
Work-study	125,000,000	125,000,000	250,000,000
Cooperative education	800,000	7,200,000	8,000,000
Subtotal, other grants in Aid	1,225,800,000	132,200,000	1,358,000,000
Library Resources:			
Librarian training	---	---	---
Educational Activities Overseas:			
Fellowships	1,735,294	---	1,735,294
Training grants	264,706	---	264,706
TOTAL:			
Fellowships	10,665,294	5,500,000	16,165,294
Training grants	444,706	---	444,706
Loans (not volume)	75,480,000	405,169,000	480,649,000
Other Grants in Aid	1,225,800,000	132,200,000	1,358,000,000

T-13

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Student Aid and Training Programs

National Institutes of Health

	1977		
	New	Continuing	Total
National Cancer Institute:			
Fellowships........................	$ 1,593,000	$14,806,000	$16,399,000
Training grants....................	---	1,764,000	1,764,000
National Heart and Lung Institute:			
Fellowships........................	---	7,636,000	7,636,000
Training grants....................	---	5,152,000	5,152,000
National Institute of Dental Research:			
Fellowships........................	---	1,865,000	1,865,000
Training grants....................	---	1,266,000	1,266,000
National Institute of Arthritis, Metabolism, and Digestive Diseases:			
Fellowships........................	1,144,000	4,739,000	5,883,000
Training grants....................	---	---	---
National Institute of Neurological and Communicative Disorders and Stroke:			
Fellowships........................	1,796,000	3,545,000	5,341,000
Training grants....................	---	---	---
National Institute of Allergy and Infectious Diseases:			
Fellowships........................	1,900,000	3,061,000	4,961,000
Training grants....................	---	2,000,000	2,000,000
National Institute of General Medical Sciences:			
Fellowships........................	3,031,000	20,200,000	23,231,000
Training grants....................	---	17,620,000	17,620,000
National Institute of Child Health and Human Development:			
Fellowships........................	828,000	2,720,000	3,548,000
Training grants....................	---	3,797,000	3,797,000
National Institute on Aging:			
Fellowships........................	645,000	286,000	931,000
Training grants....................	---	659,000	659,000
National Eye Institute:			
Fellowships........................	---	2,653,000	2,653,000
Training grants....................	---	1,187,000	1,187,000

Student Aid and Training Programs--Continued

National Institutes of Health

	1977		
	New	Continuing	Total
National Institute of Environmental Health Sciences:			
Fellowships..........................	$ 580,000	$1,038,000	$1,618,000
Training grants......................	---	625,000	625,000
Research Resources:			
Fellowships..........................	99,000	266,000	365,000
Training grants......................	---	---	---
Total, National Institutes of Health....................	11,616,000	96,885,000	108,501,000
Fellowships...............	11,616,000	62,815,000	74,431,000
Training grants...........	---	34,070,000	34,070,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

Student Aid and Training Programs

	1977		
	New	Continuing	Total
Alcohol, Drug Abuse, and Mental Health Administration			
Alcohol, Drug Abuse and Mental Health			
Fellowships	---	2,168,000	2,168,000
Training grants	---	33,832,000	32,832,000
Health Resources Administration			
Health resources			
Scholarships	19,500,000	17,500,000	37,000,000
Fellowships	---	---	---
Loans	5,000,000	---	5,000,000
Training grants	52,300,000	31,400,000	83,700,000
Total, Public Health Service	76,800,000	84,900,000	161,700,000
Scholarships	19,500,000	17,500,000	37,000,000
Fellowships	---	2,168,000	2,168,000
Loans	5,000,000	---	5,000,000
Training grants	52,300,000	65,232,000	117,532,000

[1] The New category represents monies for students or trainees who are/or will be receiving assistance for the first time, and the Continuing category represents monies for students or trainees who will be receiving assistance or grant funds for the second or more consecutive year.

[2] Listed under continuing because the payments are mandatory.

[3] The continuing loan volume is not subject to full interest subsidy because of conversions to repayment throughout the year. Since the interest subsidy is paid during only part of the life of a loan and the special allowance loan volume are subject to each type of subsidy.

[4] All new in that there is no commitment to renew grants in following years.

HEW BUDGET CONSIDERED BY COMMITTEE

Mr. **Flood**. Now, Mr. Secretary, as you mention, the total HEW budget for fiscal year 1977 amounts to $145 billion, that is in budget authority. As you pointed out, the portion of your budget that this committee will consider amounts to $44.2 billion. Out of that $44.2 billion about $32 billion represents the programs like public assistance and medicaid, the SSI, supplemental security income, over which we exercise little or no control through the appropriations bills.

So that leaves $12.2 billion, or 8.4 percent of the total HEW budget over which we as a committee will have some kind of control. Am I correct about that?

Secretary **Mathews**. I believe those figures are substantially correct; yes, sir.

Mr. **Flood**. Now, according to our figures, the $12.2 billion, which is in the 1977 budget for controllable programs represents a cutback of over $2 billion, and that is below the 1976 appropriations for these programs—a cutback of over $2 billion. In other words now, Congress will have to increase your budget by over $2 billion just to bring all of these programs up to the current dollar level, without providing anything for inflation, anything for program expansion, anything at all.

You are new to Washington, but even so you are no amateur. Do you seriously think that there is any prospect whatever for the Congress to agree to the cutbacks like this that you are proposing?

Secretary **Mathews**. I can understand your disquiet, Mr. Chairman.

Mr. **Flood**. Well, not my disquiet. I am just asking a question. I have no disquiet. Go ahead.

Secretary **Mathews**. But I would point out that I am constantly faced, and I am sure you are too, with the assertion that total spending for health, education, and welfare programs increases by a substantial percentage every year.

It is true that there is a shift in the way these program increases—more of it is going into the uncontrollable programs, and less of it into the specific programs of operating agencies.

But, I think that the difference between, the roughly $2 billion that you referred to a minute ago, has to be understood in the context of a generally rising budget, and the great concern I think that we all have is trying to make that increase a reasonable one, and also, I guess, in the context of what I gather is some disagreement between the President and the Congress over what is the appropriate funding level.

EFFECT OF CONGRESSIONAL OVERRIDE OF 1976 BILL

Mr. **Flood**. Well, that's a careful understatement. Yes.

Now, we think your 1977 budget is based upon what you might call fictitious assumptions about the appropriations for fiscal 1976. Now, those assumptions I think were that the veto of the 1976 Labor-HEW bill would be sustained, and also that Congress would approve a total of $1.3 billion in pending rescissions.

Now, that is what you had before you. All right, now that you know that neither of these things will happen, and therefore, your 1976 appropriations are going to be about $2.2 billion, as we say, higher than expected, do you plan to amend it? Now that you are faced with a fait accompli, do you plan to amend the 1977 budget request?

Secretary **Mathews**. We do not plan to amend our proposition, but we did reflect it in our comparative figures, so there would not be any undue discrepancy.

Our first reports to you, when we described the President's budget, indicated what we did in comparison with his revised 1976 budget.

Since you in your wisdom have adopted another budget, we now describe our budget in comparative terms with this your action and report to you quite candidly, that we are in total below the appropriation level that Congress has set. And we have done all our congressional justifications based on changes from the 1976 appropriation level.

CUTBACKS IN HEALTH AND EDUCATION PROGRAMS

Mr. **Flood**. How can we possibly defend, with our experience here on the floor with all of these things, how can we possibly defend cutbacks that are aggregating over $2 billion in health and education programs? How can we possibly do that?

Secretary **Mathews**. Well, I would suggest you follow the outline that I have given you here, that there are certain programs that might be reasonably thought to have completed their assigned task, and they can be abandoned.

There are other programs that very impressive groups have argued over the years do not merit continued Federal support, and what we are proposing is that you not fund them.

Mr. **Flood**. Well, you mentioned education. And in many ways, by the way, the budget for the education programs looks very similar to those we have seen year after year after year for several years. And overall the total represents a cut of $1.5 billion. That's from just the previous year. Here you have cutbacks, you propose cutbacks in impact aid, the title I grants, student aid, libraries, a whole long list.

You know, that's a little unfortunate because it puts you in a defensive position. This budget creates the impression that education is a pretty low priority. Now, is it as bad as it appears, or have we overlooked something here?

Secretary **Mathews**. Indeed, it is not as bad as it appears and it does not reflect any position of the President that he puts education as a low priority.

Mr. **Flood**. What have we overlooked?

Secretary **Mathews**. I think first of all you have to remember that the President has, you called it an understatement, a different notion of what total Federal spending should be. If you look at what the President is recommending for education in comparison with what he thinks is the appropriate Federal budget, and what he has recommended to you before, you will find, in terms of policy, that the President continues to support the basic educational programs, and, in fact, has recommended in the context of his standards many increases for those programs.

It is true that some of the programs he recommends that you not fund. Impact aid is one. In the case of student financial assistance, however, he is proposing the full funding of the basic opportunity grant program.

We would propose a different pattern of funding, however, than the one that you have been accustomed to.

Mr. Flood. Well, I think the phrase, however, is a "realinement of priorities"—is that the phrase?

Secretary Mathews. That's right, we would end such programs as the SEOG program and recommend to you that since the block program is being given a substantial increase, that the categorical programs are duplicative and you can end the one in order to have the other.

EDUCATION BLOCK GRANTS

Mr. Flood. Now, on the block grant proposal for education.

Secretary Mathews. Right.

Mr. Flood. It sounds good in theory, but do you actually think that, coming from where you come, do you actually think that local school superintendents will support that?

Secretary Mathews. I believe this proposal is not only sound in theory, but sound financially. First of all, the overwhelming sentiment of local State officials is they would gladly trade dollars for greater flexibility; they argue repeatedly, consistently, universally that we get less for our dollar because we restrained those programs by categorical programs.

Mr. Flood. You think local school superintendents also would support a block grant?

Secretary Mathews. I think local State officials would.

Mr. Flood. Local school superintendents.

Secretary Mathews. Well, I have dealt mostly with State.

Mr. Flood. Oh.

Secretary Mathews. But, I think even local school superintendents, if I understand their arguments correctly, argue for flexibility, greater flexibility.

Mr. Flood. Well now, one of the criticisms we have heard about the block grant proposal is it will shift too much authority to the Governor. Do you agree that that is a problem? And how can we avoid it?

Secretary Mathews. I think that the State governments have developed capacities and certainly have evidenced intent to assist in some of the monumental problems of health, education, and welfare that this country has.

Mr. Flood. We said it would shift too much authority to the Governors.

Secretary Mathews. To the Governors?

Mr. Flood. Yes; is that a problem?

Secretary Mathews. No, sir. If you will look at the way we transfer those programs to the States, we transfer with the programs the mandates for broad public planning, for public hearings, for wide disclosure of programs, and we do not design these programs to be controlled by any one individual.

On the other hand since a Governor is a Governor, we would not by these actions remove him from office.

Mr. Flood. Well, that's very gracious, yes. That's very considerate. Now, under this concept of block grants, what do you see as the Federal role in elementary and secondary education—as a mere check writer, a big brother, dictator or what?

Secretary Mathews. My views very happily coincide with those of the Constitution in this matter. I think elementary and secondary education, indeed, education is a matter left to the State governments.

We as a Federal Government are now only funding about 5 or 6 percent of the total dollars in those systems, and I believe our funding is concentrated on those matters where there has been some particular concern for a population that might not be served, disadvantaged or handicapped or some other group, and we find that States are increasing both their intent and capacity to deal with these programs and we propose to you in the block grant that we enlisted the good will, and the capacity of the States in dealing with those issues.

Mr. FLOOD. Well——

Secretary MATHEWS. So we could move in the block grant in a position more consistent with what I believe is our historic and constitutional position on it.

FEDERAL AID TO HIGHER EDUCATION

Mr. FLOOD. Well, coming yourself most recently from higher education, how do you view the Federal role in this area? Should Federal aid to higher education be increased?

Secretary MATHEWS. Well, aid to higher education, I think, should be targeted in such ways that it is most helpful. Aid to students should be increased and we have some proposed to you. The other forms of aid, I think, should be eliminated. We are proposing, for example, that you eliminate—

Mr. FLOOD. We are talking about higher education now.

Secretary MATHEW. Yes, sir. We are proposing that you eliminate certain programs. For example, in the 1860's, Congress developed a program to help produce more grain to enhance the state of the agricultural sciences in the country, a laudable and proper objective. I think we now after a little over 100 years can conclude that we have about done that job.

Mr. FLOOD. Are you talking about grain?

Secretary MATHEWS. I am talking about aid to land grant colleges, that I believe that 110 years later that we have probably done that job, and so there are some forms of aid to higher education that even those of us in higher education would argue that we have reached the point.

Mr. FLOOD. Some of it?

Secretary MATHEWS. That's right.

Mr. FLOOD. That's one you pick out. Could you think of another one?

Secretary MATHEWS. There are others I listed for you in here. But basically our program in higher education we are recommending to you is a very substantial program with some marked increases in areas of assistance to developing institutions, aid to students, aid to research components of the educational community.

Mr. FLOOD. Now, we continue, as you know, to hear about the plight of private institutions——

Secretary MATHEWS. That is true, sir.

Mr. FLOOD [continuing]. Of higher education. Is there anything the Federal Government could do or should do?

Secretary MATHEWS. Yes, sir. I am in very close contact with my colleagues in the higher institutions, having met with them recently on two occasions, and they tell me with almost one voice that the best thing we could do for them is to leave them alone. They don't hold us to any evil intent, but they say we are so interfering in their processes and in their activities that not only are we not giving them money, but that we are also taking money away by our intrusion into their daily activities, by our requirements to keep up with what they do. And they would petition you for relief, and the general movement that we make in this budget toward greater flexibility, greater tension to the capacities at local levels I think would be in general sympathy with what they are asking.

INDIRECT COST REGULATIONS

Mr. FLOOD. Well, you know, we have received many, many inquiries from colleges and universities all over the land about these new HEW rules for reimbursement for indirect costs.

Secretary MATHEWS. Yes, sir.

Mr. FLOOD. Or overhead.

Secretary MATHEWS. That's right.

Mr. FLOOD. Now, of course, this commitee, as you know, is very much concerned about excessive overhead costs and expenses, and grants and contracts, but it seems these new rules are overly restrictive, inequitable. Would you comment on that?

Secretary MATHEWS. Yes; I can. As you might imagine, I am not unfamiliar with this and the same people that have talked to you probably have talked to me.

Mr. FLOOD. Sure.

Secretary MATHEWS. Our position on that is we are not opposed to indirect costs, we simply feel there should be better control over those costs. We have made certain proposals, or Mr. Young, who is responsible for this, and who is our chief negotiator has made certain proposals to the institutions for better control over indirect costs, and he is quite open to their comments, and to any modifications that they would like to suggest in our proposal.

Mr. Young, would you like to comment on that?

Mr. YOUNG. I would like to point out to the chairman and the members of the committee that the business of revising or proposing to revise the indirect cost regulations is in direct response to the concerns of this committee as exemplified in the investigative report of last year.

Mr. FLOOD. I was going to say, as I know you know, I suppose, our investigative staff did a study of the indirect cost reimbursement last year and gave us a great deal of information on the subject, so without objection at this point we will place that in the record.

[The information follows:]

NOT FOR RELEASE UNTIL AUTHORIZED BY THE COMMITTEE

A REPORT TO
THE COMMITTEE ON APPROPRIATIONS
U. S. HOUSE OF REPRESENTATIVES

on

OVERHEAD REIMBURSEMENT TO GRANTEES AND CONTRACTORS
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Surveys and Investigations Staff

March 1975

NOT FOR RELEASE UNTIL AUTHORIZED BY THE COMMITTEE

March 10, 1975

MEMORANDUM FOR THE CHAIRMAN

Re: Overhead Reimbursement to Grantees and Contractors
Department of Health, Education, and Welfare

By directive dated July 8, 1974, the Committee requested that a study be made of the overhead reimbursement policy of the Department of Health, Education, and Welfare with regard to grantees and contractors.

The study has been completed and the results are included in this report.

Respectfully submitted,

C R Anderson
C. R. Anderson
Chief of the Surveys and
Investigations Staff
House Appropriations Committee

David A Schmidt
David A. Schmidt, Director
Surveys and Investigations Staff
House Appropriations Committee

TABLE OF CONTENTS

		Page
	PREFACE	i
I.	INTRODUCTION	1
	A. Directive	1
	B. Scope of Study	1
	C. Definitions	3
II.	THE NATURE OF INDIRECT COSTS	6
	A. Classification of Costs	6
	B. Indirect Cost Rates and Bases	8
	1. Computation of an Indirect Cost Rate	8
	2. Comparison of Indirect Cost Rates	11
	3. Types of Bases	17
	4. Changes in Rates	21
III.	PRINCIPLES FOR DETERMINING COSTS APPLICABLE TO GRANTS AND CONTRACTS	24
	A. Historical Development of Cost Principles	24
	B. OMB Circular A-21	26
	C. OMB Circular A-87	28
	D. Hospitals	31
	E. Other Nonprofit Institutions	32
IV.	NEGOTIATION OF INDIRECT COST RATE AGREEMENTS	34
	A. Negotiation by Designated Federal Agency	34
	B. Negotiation Procedures	35

Page

V. INDIRECT COST REIMBURSEMENT 40

A. HEW Financial Assistance and Project Grants 42

B. Public Health Service 47

C. National Institutes of Health 51

D. Social and Rehabilitation Service 60

E. Social Security Administration 61

F. Office of Education 62

G. National Institute of Education 62

H. Office of the Assistant Secretary for Planning and Evaluation 63

I. Review of Grantee Files 64

VI. CONTROL OF OVERHEAD COSTS 68

A. Limitations on Overhead Reimbursement 68

B. Negotiation and Audit of Indirect Cost Rates 72

C. Fiscal Review of Project Applications 77

D. Practices of Private Foundations 80

E. Consideration of Alternatives 81

VII. RECOMMENDATIONS FOR CONSIDERATION BY THE COMMITTEE 88

PREFACE

In the early stages of this study, the Investigative Staff learned that the Department of Health, Education, and Welfare (HEW) could not provide on a department-wide basis data on indirect costs, or overhead, being paid to grantees and contractors in the last 5 years. The National Institutes of Health (NIH) was able to provide total direct and indirect cost payments for research grants only. The Public Health Service (PHS) provided indirect cost information for most of its grants for FYs 1970 through 1974. No other HEW agency provided indirect cost data for more than one year. In the absence of such data, it is the opinion of the Investigative Staff that HEW is hardly in a position to control the expansion of overhead costs or to prevent the dollars currently going into overhead from increasing beyond the present level. Even if HEW were able to identify overhead dollars for all grants and contracts, such information still would be inadequate for effective control because of the lack of uniform definitions and standards as to the elements which are identified as direct and indirect costs.

The problem of indirect costs has been given intensive study by Government agencies, national advisory groups, universities, and private foundations. Before World War II, Federal expenditures for research and development at institutions of higher education were confined almost solely to grants to agricultural experiment stations connected with land-grant colleges. The National Science Foundation estimated that in 1940, Federal expenditures at educational institutions did not exceed $15 million, while by 1955 the amount being spent for research and development at educational institutions had risen to over $150 million. In FY 1974, NIH alone awarded research grants amounting to over $1 billion.

The HEW Financial Assistance Reports for FYs 1971 through 1974 show total obligations for financial assistance of $60.9 billion, $71.4 billion, $82.4 billion, and $92.4 billion, respectively. For the same years, project grants and contracts--the forms of financial assistance which pay significant amounts of overhead--amounted to $3.8 billion, $4.3 billion, $5.1 billion, and $6.5 billion.

Financial assistance totaling approximately $3.3 billion in FY 1973 and $4.7 billion in FY 1974 was for programs eligible for full or partial reimbursement of overhead. For these same years, the Investigative Staff was able to obtain amounts of indirect costs relating to only $1.6 billion and $1.9 billion, respectively, for PHS. For FY 1974 only, the Social and Rehabilitation Service (SRS) provided information on indirect costs associated with $122.9 million of direct costs of its grants; the Social Security Administration (SSA), indirect costs associated with $5.0 million of direct costs of its contracts; and the Office of the Assistant Secretary for Planning and Evaluation (OASPE), indirect costs associated with $9.9 million of direct costs of its grants.

Analysis of PHS grants administered at the headquarters level disclosed that from FY 1970 to FY 1974, total obligations increased from $1.2 billion to $1.9 billion, or 58.3 percent, while indirect costs related to these obligations increased from $153.9 million to $301.6 million, or 96.0 percent. As a percentage of PHS total obligations, indirect costs increased from 13.2 percent in FY 1970 to 15.9 percent in FY 1974.

For research grants awarded by 10 Institutes of NIH, from FY 1970 to FY 1974, total dollars awarded increased from $482.8 million to $893.5 million, or 85.1 percent, while indirect costs related to these awards increased from $107.2 million to $232.0 million, or 116.4 percent. Expressed as a percentage of total awards indirect costs increased from 22.20 percent in FY 1970 to 25.97 percent in FY 1974.

For FY 1974 only, indirect costs were 3.6 percent of the total amount of project grants of SRS; 21.6 percent of the total cost of 47 contracts of SSA; and 13.9 percent of the total cost of 19 grants awarded by OASPE.

The Investigative Staff is not recommending that HEW establish any complicated and expensive system to identify all indirect costs being paid to grantees and contractors on all its programs. However, if HEW has any serious concern about indirect costs, it should at least make some effort to identify the amount of money going into overhead as a prelude to establishing controls.

In view of the lack of comparability of indirect cost rates, the Investigative Staff was unable to develop any meaningful comparison between overhead payments to universities versus all other grantees and contractors on the basis of rates. However, a comparison was made of direct and indirect costs awarded by NIH in FY 1974 to 15 colleges and universities and to 15 other institutions. This comparison disclosed that at the colleges and universities, indirect costs represented 23.6 percent of the total grants, while at the other institutions, indirect costs represented 25.7 percent of the total grants

Cost accounting classifies costs into direct and indirect categories. There is no universal rule for classifying costs, and Federal regulations allow for variations provided that the classification adopted is applied consistently. An indirect cost, or overhead, rate. is merely a device for determining that proportion of the overhead of an institution which should be borne by each project. The overhead rate is the ratio between the indirect costs of the institution and some direct cost base, such as direct salaries and wages or total allowable direct costs. The rate is expressed as a percentage of the base, and the amount of overhead to be reimbursed to a grantee is determined by multiplying the base by the rate. There are many variations, depending upon the particular cost elements included in the base; the Indirect Cost Management System of NIH identifies 92 separate base plans.

Because of the differing classification of costs as direct or indirect by the various grantees of HEW, and the multiplicity of overhead rate bases, any comparison of indirect cost rates among institutions serves a limited value. However, analyses by one HEW regional office and by the Investigative Staff disclosed that colleges and universities generally have higher rates than other grantee institutions.

There appear to be no insurmountable obstacles in the way of establishing some reasonable standardization of cost accounting practices of similar institutions. At the very least it would appear feasible to establish some uniformity in classifying direct and indirect costs and in establishing a base for distribution of overhead. Unless and until some such uniformity is established, no meaningful comparison of institutions based on overhead rates can be made. Without such comparisons, HEW cannot measure the relative performance of its grantees and contractors or have any valid yardstick for monitoring overhead costs.

The Cost Accounting Standards Board promulgates standards designed to achieve uniformity and consistency in cost accounting principles. While the law establishing this Board refers only to defense contracts, the Board recognizes the desirability of uniform treatment of costs. While HEW grants and contracts are not subject to the standards and regulations of the Cost Accounting Standards Board, it would appear that HEW could profit from the work of the Board in its negotiation of indirect cost rates.

There is no pressing incentive for a grantee to reduce overhead costs under the present system of establishing indirect cost rates. On the contrary, the system may encourage inefficiency, as the Federal Government will pay a share of the indirect costs of the grantee. This lack of incentive is recognized by some HEW personnel, and a regional office of HEW has submitted a proposal outlining a new concept which contemplates the use of an incentive system to stabilize and reduce indirect costs. The incentive system is similar to the incentive provisions of some cost-type contracts. A target indirect cost rate would be established, and the grantee would be penalized or rewarded for variations from the target. Obviously such an incentive system could not be developed overnight, and study of the proposal may find that it is not feasible; however, any proposal to effect savings in overhead should merit serious consideration by HEW.

Office of Management and Budget (OMB) Circulars A-87 and A-88 designate certain Federal agencies to negotiate indirect cost rates with state and local units of government and with educational institutions. Under the provisions of these circulars, HEW is the cognizant agency for negotiations with state departments of health, education, and public assistance; with state governments for state-wide cost allocation plans; and with approximately 97 percent of all colleges and universities. No single Federal agency has been assigned responsibility for negotiation of rates with hospitals or other nonprofit organizations.

The negotiation of an overhead rate is based on a proposal submitted by a grantee or an applicant for a grant. The negotiation generally is a desk review of the proposal; site visits by the negotiator are infrequent. Most proposals are evaluated and negotiated without audit. The negotiation process itself is primarily a review of the proposal to verify that unallowable items are eliminated, and that allowable items are distributed properly to direct cost categories or overhead pools, in accordance with established cost principles.

OMB Circulars A-21 and A-87 prescribe principles for determining costs applicable to grants and contracts with educational institutions and state and local governments, respectively. HEW has developed similar principles applicable to hospitals and other nonprofit organizations. These various principles define allowable costs and prescribe methods for establishing an indirect cost rate. Certain items of cost are unallowable, including advertising, bad debts, entertainment, and interest expenses. The basic test of allowability of costs not excluded is that they must be reasonable, allocable, and treated consistently under generally accepted accounting principles.

Evaluation of the effectiveness of the negotiation of overhead rates is largely a subjective judgment. The negotiators try to ascertain the reasonableness and equity of the overhead pools and allocations. However, the negotiators are not efficiency experts, and they do not engage in management studies of the grantee. While the HEW negotiators and auditors try to screen the overhead pools to eliminate unallowable costs, and while they infrequently may question the reasonableness of a specific amount, they are not primarily in the area of trying to reduce or control overhead costs.

While the Investigative Staff did not identify any specific efforts being made by HEW to control the expansion of allowable overhead costs or to prevent the dollars currently going into overhead payments from increasing beyond the present level, there are some intrinsic controls in the current procedures.

The first such control is statutory or administrative limitation on the amount of overhead which may be paid to a grantee or contractor. Such a limitation is generally stated as a percentage of total direct costs. However, a grantee may circumvent such a limitation by classifying most expenses as direct rather than indirect costs. Only a precise definition of direct and indirect costs would serve to enforce such a limitation.

A second control is inherent in the negotiation procedures and audits of indirect cost rates. However, the HEW Audit Agency is rarely able to conduct an audit of an organization more frequently than once every 3 years, and in many cases the cycle is substantially longer than 3 years. In several files reviewed by the Investigative Staff, audits did serve to reduce the indirect cost rates proposed by grantees. However, practicalities must be recognized, and the Investigative Staff certainly is not proposing that all indirect cost rates should have audit support; the Audit Agency should continue to concentrate its resources at the major institutions.

A third control lies in the fiscal review of project applications by HEW personnel, particularly at the regional level. During this review, a grantee may waive all or part of the overhead reimbursement to which it is entitled in order to stay within budgetary constraints, to put more of the resources available into the substance of the project, or to apply the overhead reimbursement as some or all of its share of the cost of the project.

Indirect costs are real costs, and if full indirect costs associated with a sponsored project are not reimbursed to a grantee by the Federal Government, the grantee is making a contribution to the project. On the other hand, benefits do accrue to recipients of Government grants and contracts. And while in theory the Federal Government reimburses its grantees for indirect costs to defray the additional overhead expenses incurred by the grantee to support the sponsored project, in practice this concept is subject to question.

A study by a regional office of HEW included an analysis of 635 successive indirect cost rates in effect during the period from 1971 through 1974. The majority, 58.9 percent, of the rates included in this study remained constant, while only 24.6 percent showed an increase. However, during the period of the review, direct costs increased; as a result, a constant rate represents an increase in total indirect costs. A reasonable expectation, given an expanding base, would be a decrease in the ratio of overhead to direct costs; if this expectation materialized, the indirect cost rate should decline. The lack of such a decline suggests to the Investigative Staff that the Government may be paying more than its fair share of the overhead costs of its grantees.

In another region of HEW, a cutback in Federal grant funds resulted in a reduction of approximately $1 million in the direct cost base of a nonprofit institution which is the recipient of large amounts of Federal grant funds. This cutback led to a resultant reduction in recoupment of overhead. Therefore, the institution requested, and was granted, an increase in its indirect cost rate. If Federal costs dropped, it would seem that overhead should drop commensurately.

The U. S. Congress is not alone in its concern over the amount of grant funds going into overhead. At least one state legislature made an unsuccessful attempt to gain control of funds received by the state university as reimbursement of indirect costs related to Federal research grants.

In addition, the report of the Commission on Government Procurement, submitted to the President of the Senate and the Speaker of the House of Representatives on December 31, 1972, included a limited review of Federal grant-type assistance. The Commission concluded that Federal grant-type activities are a vast and complex collection of assistance programs functioning in a variety of ways that often are inconsistent even for similar programs or projects. This situation generates confusion, frustration, uncertainty, ineffectiveness, and waste. The Commission traced this disarray to confusion of grant-type assistance with procurement activities, failure to recognize that there is more than one kind of grant-type transactions, and lack of Government-wide guidance for Federal grant-type transactions.

The Commission recommended legislation to distinguish assistance from procurement, and urged the Office of Federal Procurement Policy to undertake or sponsor a study to develop a system of guidance for Federal assistance programs and periodically inform the Congress of the progress of this study.

In the event that the Office of Federal Procurement Policy does institute a study of Federal assistance programs, it is the opinion of the Investigative Staff that the problem of indirect costs should be included in the agenda.

The question as to whether or not the Federal Government should pay a part or all of the indirect costs of its grantees and contractors is a philosophic question which is not within the scope of this study. Certainly, however, this is a reasonable question, and the Investigative Staff believes that the grantors should review their concepts regarding how much of the general costs of a grantee or contractor should be borne by the Federal Government.

I. INTRODUCTION

A. Directive

By directive dated July 8, 1974, the Committee requested that a study be made of the overhead reimbursement policy of the Department of Health, Education, and Welfare (HEW) with regard to grantees and contractors. The directive stated that the purpose of the study would be to determine how effectively HEW has negotiated overhead rates in accordance with the Office of Management and Budget (OMB) Circulars A-21 and A-87.

The directive continued that specifically the study should review the rate of increase in overhead payments to grantees and contractors in the last 5 years; the level of overhead payments to universities versus all other grantees and contractors; and the efforts being made by HEW to control the expansion of allowable overhead costs as permitted by the OMB Circulars.

In addition, the directive stated that the study should include recommendations on how to prevent the dollars currently going into overhead payments from increasing beyond the present estimated level of 25 percent of funds appropriated for grants and contracts.

B. Scope of Study

Early in this study, the Investigative Staff learned that HEW could not provide Department-wide figures showing the amounts of payments for overhead for all of its grants and contracts for the past 5 years. The National Institutes of Health (NIH) did provide such data for its research grants, and the Public Health Service (PHS) provided a limited amount of such data for grants. The other components of HEW either were not able to provide such information, or were able to provide such information for only 1 year. Accordingly, the statistical data on overhead reimbursement presented in this report is limited in scope and represents only a portion of the overhead costs of HEW.

The Investigative Staff reviewed the policies, regulations, and procedures of HEW and the pertinent OMB circulars regarding the negotiations of overhead rates and the reimbursement of overhead. The overhead rates developed relate to recipients of project, or discretionary, grants; therefore, the Investigative Staff excluded from this study the payment of indirect or administrative costs related to formula grants.

The responsibility for setting policy for the negotiation of overhead rates in HEW is in the Division of Financial Management Standards and Procedures in the Office of the Assistant Secretary, Comptroller. That Division was the focal point of this study. In addition, the Investigative Staff contacted appropriate personnel of the various operating components of HEW in the Washington, D. C., area, including: The Office of Grants and Procurement Management; the Division of Budget Review and the Division of Financial Management Reporting in the Office of the Assistant Secretary, Comptroller; the Office of the Assistant Secretary for Planning and Evaluation; the Office of Education (OE); the National Institute of Education (NIE); PHS; NIH; the Social and Rehabilitation Service (SRS); and the Social Security Administration (SSA). Because the actual negotiation of overhead rates has been decentralized to the regional offices of HEW, and because many of the project grants are awarded at the regional level, the Investigative Staff visited 5 of the 10 regional offices: Region I, Boston, Massachusetts; Region V, Chicago, Illinois; Region VI, Dallas, Texas; Region VIII, Denver, Colorado; and Region IX, San Francisco, California. In each of the regional offices, the Investigative Staff also contacted representatives of the HEW Audit Agency, PHS, OE, and SRS.

The development of overhead rates is affected substantially by the classification of costs as direct or indirect and the selection of a base to which the overhead rate is applied. The Investigative Staff learned that there are no regulations or guidelines to prescribe which costs shall be classified as direct and which as indirect, and the recipients of grants differ widely in their treatment of costs. There are over 90 bases being used by grantees. The Investigative Staff contacted representatives of the Cost Accounting Standards Board to determine the progress of that Board in developing standards which might be adapted to the development of overhead rates. Although the Investigative Staff developed some tabulations comparing overhead rates of colleges and universities with those of other grantees and contractors, such comparisons are of limited value and validity because of the wide disparity in the treatment of costs as direct or indirect and in the selection of bases to which the rates are applied.

The Investigative Staff solicited information from 26 of the largest private foundations which award grants to colleges and universities and other recipients; 23 of the foundations responded. The responses evidenced a variety of methods used by the foundations in their allowance or disallowance of overhead reimbursement to grantees.

C. Definitions

Overhead is synonymous with indirect costs. OMB Circulars A-21 and A-87, as well as HEW regulations and manuals, use the terminology "indirect costs" rather than the term "overhead."

The term "grant" as used in this report means money paid by the Federal Government to an eligible recipient under programs that provide financial assistance. The term also includes such financial assistance when provided by contract, but does not include any ordinary procurement actions subject to Federal Procurement Regulations or other assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct appropriations.

There are 2 broad categories of grants--discretionary or project grants, and formula grants.

A discretionary or project grant is made in support of an individual project in accordance with legislation which permits the granting agency to exercise judgment in selecting the project, the grantee, and the amount of the award.

A formula grant is made on the basis of an allocation prescribed in legislation or regulation, rather than on the basis of an individual project review. The formula may be based on such factors as population, per capita income, enrollment, mortality, or other groupings. Formula grants generally are mandatory. In order to receive funds from its annual allotment under a formula grant program, a state generally must receive approval of its state plan and its overall budget from the awarding agency.

Certain management functions formerly within OMB have been transferred to the General Services Administration (GSA). As a result of this transfer of functions, certain OMB Circulars have been republished by GSA as Federal Management Circulars (FMC). The new designations of the circulars are as follows:

OMB Circular A-21 is now FMC 73-8.
OMB Circular A-87 is now FMC 74-4.
OMB Circular A-88 is now FMC 73-6.

The former OMB designations are still in common usage in HEW. Much of the literature on the subject still retains the OMB designations; HEW regulations and forms have not yet been completely revised to show the current FMC designation; and the HEW personnel contacted by the Investigative Staff during this study still use the OMB terminology. In addition, the directive requesting this study refers to OMB Circulars A-21 and A-87.

4

Accordingly, the OMB Circular numbers are used in this report for the convenience of the reader rather than the less familiar FMC numbers.

II. THE NATURE OF INDIRECT COSTS

A. Classification of Costs

Cost accounting classifies costs into direct and indirect categories. Direct costs are those costs that are readily traceable to some segment of operations--a product, a department, or a service, for example. Direct costs might include such items as salaries and wages for individuals employed on a given project, travel expenses of such individuals incurred in the performance of the work, and supplies used in the operation.

Indirect costs are those costs of an institution which are not readily identifiable with a particular product, project, or activity, or which are difficult or impossible to trace to a given segment. The cost of operating and maintaining buildings and equipment, depreciation or use charges, general and departmental administrative salaries and expenses, heat, light, and power, and library costs are types of expenses usually considered as indirect costs.

The classification of costs as direct or indirect is important in accounting. Indirect costs, while not readily identifiable with a particular project or activity, nevertheless are real costs necessary to the general operation of the institution and the conduct of its activities. In theory, all costs might be treated as direct costs. Practical difficulties, however, preclude such an approach. Therefore, indirect costs usually are grouped into a common pool, or pools, and distributed to those activities which benefit from them through an indirect cost rate.

There is no universal rule for classifying costs. The decision as to which cost elements are treated as direct and which as indirect can vary among different institutions. Federal reimbursement regulations allow for such variations; however, once an institution makes an election and treats a given cost as direct or indirect, it must apply that treatment consistently.

The Cost Accounting Standards Board, an agent of the Congress and independent of the executive branch, promulgates cost accounting standards designed to achieve uniformity and consistency in cost accounting principles. The law establishing the Cost Accounting Standards Board refers only to defense contracts; therefore, none of its promulgations are binding on grants. The minimum contract covered is $500,000. Only those colleges and universities having defense contracts in excess of this minimum are subject to Board standards; as a result, very few colleges and universities are covered.

While the Cost Accounting Standards Board was established to function in the area of defense contractors, it recognized that cooperation by all departments and agencies of the executive branch would be very important in achieving the full benefits of its regulations and standards. To achieve such cooperation, the Board established in 1972 an Interagency Advisory Committee composed of comptroller and procurement representatives of a number of Federal departments and agencies, including HEW. GSA, in its publication of Federal Procurement Regulations, has provided that, with certain exceptions, the promulgations of the Board are to be extended to nondefense contracts; however, colleges and universities are exempt as far as their nondefense contracts are concerned. At the present time, the work of the Cost Accounting Standards Board has not been broadened to include hospitals or other nonprofit organizations, with the exception of a few large nonprofit organizations such as the Stanford Research Institute and Rand Corporation which have defense contracts which are covered.

The Cost Accounting Standards Board recognizes the desirability of uniform treatment of costs by all contractors as far as possible. The first 2 standards promulgated by the Board deal with consistency in estimating, accumulating, and reporting costs, and with consistency in allocating costs incurred for the same purpose. However, the consistency required applies only to the accounting practices of each individual contractor; the standards do not yet require consistency among all contractors.

An ongoing study of the Board which is of particular relevance to the reimbursement of indirect costs relates to the accounting concepts and principles governing the consistent classification of costs as direct or indirect for the purpose of allocation to cost objectives. This study is still in its early stages.

B. Indirect Cost Rates and Bases

1. Computation of an Indirect Cost Rate

An indirect cost rate, or overhead rate, is a device for determining that proportion of the overhead which should be borne by each project, activity, or product of an institution or organization. The overhead rate is a ratio between the indirect costs of the institution and some direct cost base. The base may be, for example, direct salaries and wages, which is a base commonly used by colleges and universities. However, the base may be total allowable direct costs, the allowable direct costs usually excluding capital expenditures, subcontracts, and other costs which may distort the base.

The computation of an overhead rate is illustrated by the following simplified example:

	Direct Costs	Indirect Costs
Salaries and wages	$100,000	(detail omitted)
Fringe benefits	10,000	
Travel	5,000	
Direct supplies	15,000	
Other direct expenses	20,000	
Total	$150,000	$50,000

In this example, if the base is direct salaries and wages, excluding fringe benefits, the overhead rate would be $50,000 (total indirect costs) divided by $100,000 (direct salaries and wages) or 50.0 percent. In the same example, if the base is salaries and wages, including fringe benefits, the rate would be $50,000 (total indirect costs) divided by $110,000 (total direct salaries and wages plus fringe benefits) or 45.5 percent. If the base is total direct costs, the rate would be $50,000 (total indirect costs) divided by $150,000 (total direct costs) or 33.3 percent.

The rate can equal or exceed 100 percent. Such a situation would occur if the total indirect costs of the institution equal or exceed the total direct costs.

In applying the indirect cost rate to a particular project or grant at the institution in this example, the rate would be applied to the appropriate base. Thus, a particular project may have incurred direct costs as follows:

$10,000	salaries and wages
1,000	fringe benefits
500	travel
1,500	direct supplies
2,000	other direct expenses
$15,000	total direct costs

Using the 3 bases described above, the overhead for this particular project would be computed as follows:

(a) On a direct salaries and wages base, excluding fringe benefits:

$10,000	direct salaries and wages
x 50%	rate
$ 5,000	overhead

(b) On a direct salaries and wages base, including fringe benefits:

$11,000 direct salaries and wages and fringe benefits
x 45.5% rate

$ 5,005 overhead

(c) On a total direct cost base:

$15,000 total direct costs
x 33.3% rate

$ 4,995 overhead

In theory, then, the selection of the base has no significant effect on the overhead where other conditions remain constant. In practice, however, selection of a proper base is very important. For example, if a direct salaries and wages base is used, a project or activity incurring a large proportion of personnel costs would bear more overhead than a project in which personnel costs are a smaller proportion of the total costs.

When indirect cost reimbursement is limited to a specific percentage, grantees have an incentive to classify more of their expenses as direct costs. A grantee with a substantial income from Federal grant sources may develop a sophisticated accounting system to allocate most of its costs directly and so "beat" any limitation. The problem lies in the lack of a precise definition of direct and indirect costs, and in the lack of any standards requiring grantees to classify specific costs as either direct or indirect. Without such precise definitions and standards, a limitation may defeat its own intent; and it would be extremely difficult to formulate, apply, and enforce any such definitions and standards. Use of a more standardized approach to indirect cost rate determination and presentation would be helpful to the grantees, auditors, and negotiators.

2. Comparison of Indirect Cost Rates

At the request of the American Council on Education, the accounting firm of Peat, Marwick, Mitchell and Company conducted a study of the variations in indirect cost rates applicable to federally sponsored research conducted by universities. The report on this study, submitted by letter dated February 14, 1969, stated that the study was designed to provide the Ad Hoc Committee on Indirect Costs of the American Council on Education with information which would assist in clarifying questions raised by the Congress on indirect costs, their relationship to the performance of research, and the rates developed for allocation of indirect costs to research projects.

The initial concern giving rise to this study stemmed from the suggestion that universities might be profiting unfairly from federally sponsored research projects. The cover letter transmitting the report stated that the study indicated exactly the opposite condition. The letter stated that because of the cost allocation principles which are applied uniquely to educational institutions, the universities are not recovering costs which are important to their ability to sustain a desirable research capability; other organizations, including nonprofit institutions, do recover such costs.

A sample of 6 universities was selected for the study, consisting of 3 publicly supported and 3 privately supported institutions. The study showed that these 6 universities collectively developed 19 different indirect cost rates applicable to research projects; the rates ranged from a low of 18.11 percent to a high of 76.09 percent. Multiple campuses, special facilities, and off-campus research activities accounted for the multiplicity of rates.

Because of the variations found among the 6 universities included in the sample, the study concluded that indirect cost rates could not be used as a measure of relative cost to support research. The rates are useful only as devices to determine the total cost of a research project. The study concluded that indirect cost rates have little bearing on any comparative evaluation of research efforts; these may be measured perhaps by the total cost, but not by the relative distribution of direct and indirect costs.

The study found that the main cause of rate differences (assuming the same base is used) is the treatment of a particular element of cost as direct or indirect. In theory, treatment of a cost as direct or indirect should have no effect. In practice, it was found that charging more elements as direct costs not only lowered the indirect cost rate but also led to a higher reimbursement of total costs.

A study conducted by the Cost Review and Assistance Division of HEW Region I, Boston, compared rates for the various types of grantees--colleges and universities, state and local governments, hospitals, and nonprofits--within various strata of ranges at 10 percent intervals. This phase of the study compared only institutions with a like base.

The results of this comparison for institutions using a salaries and wages base are shown on the following page.

COMPARISON FOR INSTITUTIONS
SALARIES AND WAGES BASE

Indirect Cost Rate Range (In Percent)	Colleges and Universities		State and Local Governments		Hospitals		Nonprofits		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0 - 9	-	-	46	23.1	-	-	1	2.0	47	11.4
10 - 19	-	-	43	21.6	-	-	5	10.0	48	11.6
20 - 29	-	-	40	20.1	4	14.8	6	12.0	50	12.1
30 - 39	26	19.0	33	16.6	8	29.6	4	8.0	71	17.2
40 - 49	37	27.0	16	8.0	10	37.1	7	14.0	70	17.0
50 - 59	14	10.2	21	10.6	5	18.5	13	26.0	53	12.8
60 - 69	39	28.5	-	-	-	-	14	28.0	53	12.8
70 - 79	10	7.3	-	-	-	-	-	-	10	2.4
80 or higher	11	8.0	-	-	-	-	-	-	11	2.7
Total	137	100.0%	199	100.0%	27	100.0%	50	100.0%	413	100.0%

The results of the foregoing comparison for institutions using a total direct cost base follow:

COMPARISON FOR INSTITUTIONS
DIRECT COSTS BASE

Indirect Cost Rate Range (In Percent)	Colleges and Universities		State and Local Governments		Hospitals		Nonprofits		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0 - 9	-	-	72	26.2	-	-	8	11.6	80	20.8
10 - 19	-	-	58	21.1	-	-	15	21.7	73	19.0
20 - 29	-	-	31	11.3	18	43.9	22	31.9	71	18.4
30 - 39	-	-	60	21.8	14	34.2	12	17.4	86	22.3
40 - 49	-	-	37	13.4	6	14.6	7	10.1	50	13.0
50 - 59	-	-	17	6.2	3	7.3	5	7.3	25	6.5
Total			275	100.0%	41	100.0%	69	100.0%	385	100.0%

The comparability of rates, even with this separation by base, is still subject to the lack of uniformity of direct and indirect costs from one institution to another.

The Investigative Staff reviewed and tabulated 638 indirect cost rates in 3 regional offices. The schedule on the following page shows a comparison of rates, by type of base, within ranges of 10 percent.

COMPARISON OF COLLEGE AND UNIVERSITY RATES WITH ALL OTHER INSTITUTIONS RATES

Range of Rates (In Percent)	Salaries and Wages Base				Total Direct Cost Base			
	Colleges and Universities		All Other Institutions		Colleges and Universities		All Other Institutions	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0 - 9	2	.9	5	3.4	-	-	61	22.8
10 - 19	2	.9	13	9.0	-	-	63	23.5
20 - 29	9	4.1	30	20.7	-	-	68	25.4
30 - 39	30	13.6	21	14.5	2	40.0	38	14.2
40 - 49	43	19.6	19	13.1	2	40.0	24	8.9
50 - 59	58	26.4	19	13.1	1	20.0	9	3.3
60 - 69	48	21.8	19	13.1	-	-	3	1.1
70 - 79	18	8.2	10	6.9	-	-	-	-
80 - 89	6	2.7	3	2.1	-	-	-	-
90 - 99	-	-	2	1.4	-	-	1	.4
100 and over	4	1.8	4	2.7	-	-	1	.4
Total	220	100.0%	145	100.0%	5	100.0%	268	100.0%

The comparison prepared by the Investigative Staff of indirect cost rates revealed that 60.9 percent of the colleges and universities using a salaries and wages base have rates over 50 percent, while only 39.3 percent of the other institutions using the same base have rates over 50 percent. The comparison of rates having a total direct cost base revealed no colleges and universities having rates under 30 percent, while 71.7 percent of the other institutions had rates under 30 percent.

The following table shows the average indirect cost rates for the 638 institutions:

	Base	
	Salaries and Wages	Total Direct Cost
Colleges and universities	53.7%	43.0%
State and local governments	27.9	22.6
Hospitals	40.9	31.1
Nonprofit institutions	51.3	21.9

This table illustrates the differences in rates caused by the type of base used. The salaries and wages base for each type of institution resulted in higher indirect cost rates than the total direct cost base.

3. Types of Bases

The list on the following page shows the distribution of the 638 institutions by the type of base used.

	Salaries and Wages Base		Total Direct Cost Base		
	Number of Institutions	Percent	Number of Institutions	Percent	Total Institutions
Colleges and universities	220	98	5	2	225
State and local governments	52	34	101	66	153
Hospitals	22	40	33	60	55
Nonprofit institutions	71	35	134	65	205
Total	365	57%	273	43%	638

In the preceding tables, the Investigative Staff showed only 2 bases, direct salaries and wages and total direct costs. This is an oversimplification of the variety of bases used by the numerous organizations and institutions receiving grants and contracts from HEW. While direct salaries and wages and total direct costs are the 2 primary classifications of bases, within each classification are numerous subclassifications. Each subclassification defines more precisely the cost elements included in the specific base.

For example, the direct salaries and wages base may include no fringe benefits, some fringe benefits, or all fringe benefits. Fringe benefits are allowances and services provided by the employer to the employees as compensation in addition to regular salaries and wages. The list of types of fringe benefits which an employer may grant is lengthy, and may include such items as vacation, holiday, and sick pay; bereavement, military, sabbatical, and jury duty leave, health and life insurance; pension plan; and such mandatory requirements as Social Security taxes, unemployment compensation insurance, and workmen's compensation insurance.

Treatment of fringe benefits is very individualized. An institution may treat fringe benefits as indirect costs or direct costs, or may treat some fringe benefits as direct and some as indirect. For example, many institutions treat vacation, holiday, and sick pay as regular compensation; in such cases, these benefits are charged as direct salaries and wages. Some fringe benefits, such as pension plans and hospitalization insurance, may be readily identified with particular individuals, and some institutions charge these benefits directly. Other costs, such as workmen's compensation insurance and unemployment compensation insurance, are not easily identified with particular employees, and some institutions charge these benefits to indirect cost pools. Regardless of the method of costing such benefits, the institution must do it consistently.

Inasmuch as fringe benefits have been estimated to amount to about 28.7 percent of industrial payrolls, the method of classifying fringe benefits as direct or indirect costs can affect the indirect cost rate substantially.

Likewise, there are numerous variations in the definition of allowable elements included in the total direct cost base. Excluded may be major subcontracts, capital expenditures, alterations, and renovations. In addition, dollar limitations may be attached to any of these excluded elements, such as the exclusion only of major subcontracts or capital expenditures in excess of $50,000, or any other stated amount.

The Indirect Cost Management System of NIH contains a computerized listing of the indirect cost rates and bases used by its research grantees. This listing contains 92 separate base plans, as well as 70 different treatments of fringe benefits. The Investigative Staff selected 70 institutions in this System for a review of base plans. The table on the following page illustrates the variety of base plans used by these 70 institutions.

Base Plan	Institutions Number	Institutions Percent
Direct salaries and wages including vacation, holiday, and sick pay, but excluding other fringe benefits.	39	55.7
Direct salaries and wages including fringe benefits.	10	14.3
Total direct costs less items of equipment, major subcontracts, alterations and renovations, hospitalization per diem fees and other fees related to patient care.	6	8.6
Total direct costs less expenditures for equipment, expenditures over $50,000 on single subcontracts with parties outside of the university, expenditures over $50,000 for single purchases from third parties of hospitalization and other services related to patient care, and expenditures for alterations and renovations.	4	5.7
All other bases.	11[a]	15.7
Total	70	100.0%

[a] Each of these institutions used a different base plan.

OMB Circular A-21 provides for the establishment of an indirect cost rate based on direct salaries and wages. However, the circular permits a direct cost base other than salaries and wages where it can be demonstrated that greater equity results. A college or university may want to change its base from salaries and wages to reduce its stated indirect cost rate by allocating its indirect costs over a broader base. The resulting lower rate does not reduce the amount of overhead recovered, but it gives the appearance of doing so. The administration of the university may find it easier to "sell" a lower rate to the faculty members receiving research grants.

Professional staff employees of the Cost Accounting Standards Board told the Investigative Staff that there appears to be no insurmountable obstacle in the way of establishing some reasonable standardization of cost accounting practices of similar institutions, such as colleges and universities. At the very least it would appear feasible to establish some uniformity in classifying direct and indirect costs, in the treatment of fringe benefits, and in establishing a direct cost base for distribution of indirect costs. For example, a base consisting of direct salaries and wages, including vacation, holiday, and sick pay, but excluding all other fringe benefits, is a practical method, relatively simple to establish. In addition, direct salaries and wages is a reasonably equitable base on which to allocate overhead in an institution such as a college or university where indirect costs are primarily for the support of the faculty.

Deviations from a direct salaries and wages base including vacation, holiday, and sick pay, but excluding all other fringe benefits, may be made by an institution primarily for either of 2 reasons:

(a) Cosmetic. Inclusion of additional elements in the base, such as other fringe benefits or total allowable direct costs, serve mainly to reduce the stated indirect cost rate. Other things being equal, the total cost is not affected substantially.

(b) To defeat an established indirect cost rate ceiling. If an arbitrary ceiling on recovery of indirect costs is established by statute or regulation, it is to the advantage of the grantee or contractor to include as direct costs as many of his expenses as possible. If this approach is completely successful, the grantee or contractor will have an indirect cost rate which is below the ceiling, and thus will recover all his costs despite the limitation.

4. Change in Rates

An analysis was made by NIH in May 1973 of changes from FY 1970 to FY 1973 in indirect cost rates of 60 grantees, consisting of 20 colleges and universities, 20 hospitals, and 20 other nonprofit organizations. The analysis was based on a simple unweighted average, and included fixed, final, and provisional rates.

The number of institutions in this analysis which had increases, decreases, or no change in rates is shown in the following table:

	Increased	No Change	Decreased
Colleges and universities	17	1	2
Hospitals	15	1	4
Nonprofit organizations	12	2	6
	44 (73.3%)	4 (6.7%)	12 (20.0%)

The average rates for the institutions in the analysis all increased, as shown in the following table:

	FY 1970	FY 1973	Percent of Increase
Colleges and universities	46.43%	53.03%	14.2%
Hospitals	38.78	41.63	7.3
Nonprofit organizations	32.69	34.60	5.8
All Institutions	39.30%	43.09%	9.6%

This analysis did not identify the base to which the indirect cost rate is applied. Other data gathered by the Investigative Staff during the course of this study show that most colleges and universities use a direct salaries and wages base, while more hospitals and other nonprofit organizations use a total direct cost base. Consequently, the foregoing data do not represent a fair comparison of colleges and universities with hospitals and other nonprofit organizations. However, the analysis does show the comparative percentage of increase in rates of the various types of institutions.

The study made by the Cost Review and Assistance Division of HEW Region I, mentioned previously in this report, included an analysis of indirect cost rates in that region for the period from 1971 through 1974. The study compared 635 successive indirect cost rates in effect during this period; provisional rates were excluded.

The study attempted to show, for the selected sample, whether the rates remained constant, increased, or decreased for the period. The results were as follows:

	Number	Percent
Rate remained constant	374	58.9%
Rate increased	156	24.6
Rate decreased	105	16.5
Total	635	100.0%

While the foregoing tabulation reflects that the majority of the rates remained constant, it is noted that of the 261 changes in indirect cost rates, 156 of the changes, or 59.8 percent, were increases.

During the period of the review, direct costs increased, as a result, a constant rate represents an increase in total indirect costs. A reasonable expectation, given an expanding base, would be a decrease in the ratio of overhead to direct costs, because overhead includes some fixed charges; if this expectation materialized, the indirect cost rate should decline. The lack of a decline suggests that the current system of indirect cost reimbursement does not encourage grantees and contractors to seek savings in overhead.

III. PRINCIPLES FOR DETERMINING COSTS APPLICABLE TO GRANTS AND CONTRACTS

A. Historical Development of Cost Principles

Support of project research on a large scale was undertaken by the Office of Scientific Research and Development during World War II. Research services were purchased from nonprofit institutions, mainly universities, under cost-type contracts which provided for no profit or loss. For the first time, the indirect cost question became acute, not as to whether or not such costs should be paid, but rather as to how much they were and what constituted such costs.

At the close of World War II, support for research projects was continued by a number of Government agencies. The Office of Naval Research took the lead in negotiating indirect cost rates with individual colleges and universities. In the ensuing years, principles were developed for determination of costs under Government research and development contracts with educational institutions. These principles eventually were incorporated in Section XV of the Armed Services Procurement Regulations in 1949, and these principles still serve as the basic rules for determining what the indirect costs are on most military contracts with colleges and universities.

In June 1955, the National Science Foundation submitted a report to the Bureau of the Budget recommending a uniform policy for paying the indirect costs of research supported by the Federal Government at colleges and universities. The Foundation recommended that, as a Government-wide policy, Federal agencies reimburse educational institutions for those indirect costs associated with the direct costs of sponsored research.

The National Science Foundation report was sent by the Bureau of the Budget to the Federal agencies for comment, and the agencies agreed to the formation of an interagency committee to develop principles for the determination of indirect costs for Government-wide use. In October 1956, the task of developing such principles was assigned by the Bureau of the Budget to an interagency committee consisting of representatives of several Federal departments and agencies, including HEW. A representative of the Bureau of the Budget was the chairman of the interagency committee. The committee examined the existing principles and practices followed by Federal agencies in determining and paying overhead costs for research performed by universities under grants and contracts with the Federal Government.

In April 1957, the interagency committee completed a draft of recommended policies and principles to be followed by all Federal agencies in determining the allowable costs of research and development performed by educational institutions. The draft was sent to 3 university groups for review and comment, as well as to interested Federal agencies.

The results of the work of the interagency committee, as developed and modified by the Federal agencies and educational community, eventually resulted in the publication of OMB Circular A-21.

There are currently 4 sets of cost principles governing grants and contracts awarded by HEW.

OMB Circuler A-21, which is Government-wide in application, contains principles for determining costs applicable to grants and contracts with educational institutions.

OMB Circular A-87, which also is Government-wide in application, contains principles for determining costs applicable to grants and contracts with state and local governments.

The other 2 sets of cost principles apply to hospitals and to other nonprofit organizations and institutions. These 2 sets of cost principles were developed by HEW several years ago because there are no Government-wide cost principles for these 2 kinds of grantee organizations.

B. OMB Circular A-21

OMB Circular A-21 originally established principles for determining costs applicable to research and development under grants and contracts with educational institutions. Subsequent amendments extended the cost principles to educational service agreements.

The Circular includes general standards for selected items of cost. These standards are applied in establishing the allowability of certain items, irrespective of whether the particular item is treated as a direct cost or an indirect cost. In general, these standards are similar to those covered in the Armed Services Procurement Regulations and the Federal Procurement Regulations, and include as unallowable costs such items as advertising (with certain exceptions), bad debts, entertainment costs, interest expenses, and the like.

However, the basic test of allowability of costs provided in the Circular is that they must be reasonable, allocable, and treated consistently under generally accepted accounting principles.

A cost is considered reasonable, under the principles of OMB Circular A-21, "if the nature of the goods or services acquired or applied, and the amount involved therefore, reflect the action that a prudent person would have taken under the circumstances prevailing at the time the decision to incur the cost was made."

Under the cost principles in OMB Circular A-21, there are actually 2 levels of distribution of indirect costs. The indirect costs first are accumulated in various overhead pools. The first level of distribution allocates to research that portion of the cost in each overhead pool applicable to the organized research efforts of the institution. This step includes elimination of costs unallowable under Circular A-21, and allocation of the remaining costs on some bases which have a reasonable relationship to the relative benefits received by the organized research activities. The second level of distribution then allocates the costs in the research overhead pool to individual research projects.

Under the cost accounting principles set forth in OMB Circular A-21, indirect costs that can be attributed to organized research must be segregated or removed from each department or division of the institution and set out in a separate pool of research support costs. After these support costs are segregated, they are then distributed to each research project by the application of the established rate and base.

The construction of indirect cost pools and the subsequent distribution of such costs have considerable impact on the indirect cost rate and, therefore, on the recovery of indirect costs by the institution. The colleges and universities have substantial flexibility in determining the elements included in each overhead pool. This flexibility is significant inasmuch as the overhead pools are distributed differently. Those institutions that develop a separate research administration expense pool will allocate a larger percentage of their research administrative costs to sponsored research than do institutions that do not develop such a pool.

The costs accumulated in the various overhead pools are then distributed to appropriate cost objectives; only those costs distributed to organized research will be recovered by the institution under Federal research contracts. The distribution of pool costs is a major factor in accounting for differences in indirect cost rates.

In the study of variations in research indirect cost rates conducted by Peat, Marwick, Mitchell and Company, it was determined that the effectiveness of the distribution of overhead pool costs seems to be in direct proportion to the time and effort expended by the institution on indirect cost rate development. With the flexibility allowed by OMB Circular A-21, any university could change its method of distribution, and thus perhaps recover more of its indirect costs from sponsors through its indirect cost rate, if it chose to expend the additional resources necessary to determine a more favorable distribution base.

OMB Circular A-21 provides for the development of separate indirect cost rates for research projects and for educational service activities of a college or university. An educational service agreement is a grant or contract under which Federal financing is provided on a cost reimbursement basis for training or other educational services. An indirect cost rate for educational service agreements is determined in general under the same principles used for research indirect cost rate. However, there is an additional cost pool established for student administration and services. Indirect costs applicable to the instruction activity of the institution may be allocated to educational service agreements. Research rates and educational service rates for a given period must be computed concurrently in a consistent manner.

C. OMB Circular A-87

OMB Circular A-87 establishes uniform principles for determining the costs of grants and contracts to state and local governments. This Circular also provides that federally assisted programs shall bear, in addition to direct costs, their fair share of indirect costs except where restricted or prohibited by law.

The procedures for allocating indirect costs in state and local governments necessarily differ from those used in educational institutions. OMB Circular A-87 provides that all indirect costs of the grantee state department are allowable providing that they are necessary for the efficient conduct of the grant program. In addition, a necessary cost of a grant program is allowable regardless of where it is incurred within the state complex. The costs of services provided by central service agencies of the state need not be supported by a transfer of funds between the departments involved. Cost allocation plans are the means by which such costs can be identified in a logical and uniform manner for reimbursement under Federal grants and contracts.

There are 2 types of cost allocation plans. The first covers the distribution of the cost of support services provided to state grantee or contractor agencies and is referred to as the consolidated state-wide allocation plan. The second covers the distribution of the costs within an individual operating state agency, including the costs of services allocated to it under the consolidated state-wide allocation plan, to all work performed by that agency. This second type of cost allocation plan is commonly referred to as an indirect cost rate proposal.

A consolidated state-wide cost allocation plan is used for distributing the costs of central services to state operating departments or agencies. Central services include activities such as the state civil service commission or personnel agency, motor pool, payroll, audit agency, purchasing department, and similar functions which serve the state operating agencies or departments.

Responsibility has been assigned to HEW, as the agency with the greatest interest in grants at the state level, for the approval and audit of consolidated state-wide cost allocation plans. This approval authorizes the inclusion of central service support costs in the indirect cost proposals of the individual state operating departments and agencies. When the plan is approved by HEW, the distribution of such costs to the various operating departments of the states will not be subject to question when indirect costs of the individual operating departments are reviewed by other Federal agencies, unless an agency determines that the approved plan would result in significant inequitable or improper charges to programs for which it is responsible.

Many Federal programs currently permit as direct program costs, costs which in the normal sense would be construed as indirect costs. Unless proper accounting effect is given to this practice in state-wide cost allocation plans and indirect cost rate proposals, duplication of charges may occur.

A single Federal agency is responsible for approval of the indirect cost rate proposal of each state operating agency. Responsibility lies with that Federal agency having the maximum dollar interest. A single annual negotiation of the indirect cost proposal is required, and the indirect cost rate approved is applicable to all Federal grants and contracts. HEW has been designated as the cognizant Federal agency to negotiate indirect cost proposals for state departments of health, education, and public assistance.

The principles of OMB Circular A-87 are applicable to local as well as state governments. Local governments also have 2 types of cost allocation plans a consolidated local government-wide cost allocation plan and an indirect cost rate proposal. However, local governments will not normally submit their plans for prior Federal approval unless specifically requested to do so by the cognizant Federal agency. The plans must be retained by the local government unit for subsequent Federal audit.

A state educational agency may incur indirect costs on the basis of an indirect cost rate negotiated by HEW under the principles of OMB Circular A-87. Indirect cost rates for local educational agencies requesting such rates are established by the state educational agency on the basis of a plan approved by HEW.

OMB Circular A-87 does not apply to grants and contracts with: (1) publicly financed educational institutions subject to OMB Circular A-21; or (2) publicly owned hospitals and other providers of medical care subject to requirements promulgated by the sponsoring Federal agencies. However, costs that benefit such educational institutions and hospitals, but which have been incurred elsewhere within the state complex, can be recognized as allowable and allocable costs. Therefore, there may be added to the costs of such institutions an allocable share of the central state service costs determined to be acceptable to HEW under a consolidated state-wide cost allocation plan negotiated under OMB Circular A-87.

D. Hospitals

Indirect cost rates established for hospitals differ to a great extent from rates for other types of institutions in many respects. Negotiations with hospitals cover proposals for both indirect cost rates and patient care costs. The reports submitted by hospitals under the Medicare and Medicaid programs are closely related to their indirect cost rate and patient care proposals, and these reports are the basic documents used to support such proposals. In those cases where the Medicare reports have been prepared in accordance with Social Security Administration policy, detailed analyses of the proposals generally are unwarranted. The Medicare cost principles are generally similar to the research cost principles for hospitals. However, Medicare allows 2 major cost items--depreciation on Federally financed assets and interest--which are not allowable under the research cost principles. The negotiator must assure that the indirect cost rate proposal includes an adjustment sheet to eliminate unallowable costs.

Rates applicable to hospital research grants and contracts are similar to those for other institutions, such as colleges and universities. However, the hospital agreements are largely concerned with patient care rates. These rates are set at a specified amount per day for patient care, and at a specified percentage of standard fee schedule charges for ancillary services.

E. Other Nonprofit Institutions

A nonprofit institution is any corporation, foundation, trust, cooperative, or other organization which is operated primarily for scientific, educational, service, charitable, or similar purposes, which is not organized for profit, and which uses all income exceeding costs to maintain, improve, and expand its operations. As used in this report, the term excludes educational institutions, hospitals, and state and local governments.

Because of the wide variety of nonprofit organizations, the principles governing development of indirect cost rates for such institutions are somewhat general in nature. However, there are 3 basic methods used: (1) multiple distribution base method; (2) simplified method; and (3) alternate simplified method.

The multiple distribution base method initially groups indirect costs into various overhead pools. Each of these pools is then distributed to the direct cost activities by means of a base.

The simplified method does not require a series of indirect cost pools. Instead, the total costs of the organization are adjusted by eliminating capital expenditures and other unallowable costs. The adjusted total costs then are classified as either direct or indirect. A single rate then is developed by relating the total indirect costs to a base which usually is total direct costs.

The alternate simplified method is used by those nonprofit institutions, particularly voluntary health and welfare agencies, which elect to charge directly to their programs all costs except those specifically identifiable as general administration and fund raising expenses. Under this system, the indirect costs of grants and contracts would be simply the proportionate share of the general administrative expenses, as fund raising expenses are unallowable.

IV. NEGOTIATION OF INDIRECT COST RATE AGREEMENTS

A. Negotiation by Designated Federal Agency

In the past, it was the general practice for each Federal department or agency to negotiate an indirect cost rate applicable to its own grants or contracts at a given institution. This practice resulted in inefficiency and inequities and was generally unsatisfactory to both the Federal Government and the educational community. Therefore, in May 1968, OMB issued Circular A-88.

OMB Circular A-88 sets out policies for the establishment of indirect cost rates and the auditing of Federal grants and contracts at institutions of higher learning. Each educational institution receiving Federal funds is assigned to a single Federal department or agency which is responsible for the negotiation of indirect cost rates and the audit of all Federal awards to that institution. Indirect cost rates established for a given institution by its cognizant Federal department or agency must be accepted by all other Federal departments and agencies. Under the provisions of OMB Circular A-88, one Federal agency may carry out the indirect cost rate negotiation while another may be responsible for the auditing; however, whenever possible, the same Federal agency will perform both of these related functions at a single institution.

An application for a grant or a proposal for a contract usually involves a request by the prospective recipient for both direct and indirect costs. The award of both direct and indirect costs is the responsibility of the awarding agency. However, while the direct costs of the projects must be validated by the awarding agency, the indirect costs need to be supported in the request only by a current indirect cost rate established by negotiation between the institution and the cognizant Federal department or agency.

Under OMB Circular A-88, HEW has cognizance at over 1,900 colleges and universities, or approximately 97 percent of the total.

Under OMB Circular A-87, a single Federal agency is designated to act on behalf of all Federal agencies in the negotiation of indirect cost rates and consolidated cost allocation plans with state and local governments. The rates negotiated by the cognizant agency are binding on all Federal agencies.

Formal policies and procedures have not been established to designate a single Federal agency to negotiate indirect cost rates with hospitals and other nonprofit organizations. HEW supports the principle that rates established with a given institution should be accepted by other agencies. Rates negotiated at these institutions by other Federal agencies normally will be accepted by HEW.

As a practical matter, hospitals generally do not receive grants or contracts which require the negotiation of indirect cost rates from Federal agencies other than HEW.

B. Negotiation Procedures

Each institution or organization which wishes to be reimbursed for indirect costs must submit an indirect cost rate proposal to the cognizant Federal department or agency. An institution which has been assigned to a Federal department or agency other than HEW need not submit an indirect cost proposal to HEW; instead, it submits its proposal to the cognizant agency in accordance with the instructions and regulations of that agency. The proposal should be accompanied by an audited financial statement; in addition, certain other data may be required to allow the negotiator to judge the reasonableness of the proposed rate.

Indirect cost rate proposals need not be submitted if indirect costs are not requested by the grantee or contractor, or if an institution is awarded only training grants subject to an 8 percent limitation of total direct costs and its indirect cost rate exceeds that limitation.

Prior to the latter part of 1973, such proposals from organizations for which HEW is the cognizant negotiator were submitted to the Division of Cost Policy and Negotiation, Office of the Deputy Assistant Secretary for Grant Administration Policy, Washington, D. C. Since that time, however, the indirect cost rate negotiation function has been transferred to the 10 regional offices of HEW. Organizationally, this function in the regions is under the jurisdiction of the Assistant Regional Director for Financial Management (Regional Comptroller). Overall supervision of negotiation policies and procedures in HEW now rests in the Division of Financial Management Standards and Procedures, Office of the Assistant Secretary, Comptroller.

The negotiation of an indirect cost rate generally is a desk review of the proposal submitted by a grantee or applicant. The negotiator frequently will request further information or data from the grantee, and usually contacts the grantee by telephone for additional information or clarification of information furnished. Site visits by the negotiator are infrequent. To the maximum extent possible indirect cost rate proposals are evaluated without the assistance of an audit. In some cases, however, audits are necessary; when an audit is deemed necessary, it is requested in writing to the Regional Audit Director.

The negotiation process itself is primarily a review of the proposal to verify that unallowable items are eliminated and that allowable items are distributed properly to direct cost categories or overhead pools.

In reviewing an indirect cost rate proposal, the negotiator performs sufficient analysis to provide reasonable assurance that the proposed rate is fair. The scope and depth of this analysis depends upon such factors as the size of the institution in terms of Federal grants and contracts received, the dollar amount which will result from the rate established, and whether an audit of the proposal has been conducted. The negotiator also considers the proposal in the light of previous negotiations with the institution, including such items as any significant increases in the amounts of the costs included in the current proposal compared with prior proposals, and any significant changes in the accounting system or organizational structure of the institution which may have an impact on the proposal. In some cases, where the amounts involved in the negotiation and the proposed rate do not exceed certain established levels, a proposal may be accepted without review or with only a very cursory review.

Indirect cost rates may be established as either provisional, final, predetermined, or fixed with a carry-forward provision.

A provisional indirect cost rate is a temporary rate established to allow the obligation and payment of funds on grants and contracts until actual indirect costs can be determined and a final indirect cost rate established. Normally, an institution's latest final indirect cost rate is used as its current provisional rate.

A final indirect cost rate is established after an institution's actual costs for a given accounting period (normally its fiscal year) are known. Once established, a final indirect cost rate is not subject to adjustment.

A fixed rate with a carry-forward provision is established and fixed for a specified future period. It is not subject to adjustment for the specified period; however, after the end of that specified period, if the actual rate results in an over- or under-recovery of indirect costs, the amount of over- or under-recovery is carried forward as an adjustment to the rate established for the next period.

Most indirect cost rates are established initially as provisional rates. In the event additional funds are required for indirect costs because of differences between provisional and final rates, additional funds may be provided, to the extent that they are available, from the same appropriation from which the original award was made. In the event that funds are not available in that appropriation, the operating agency may request a supplemental appropriation for the necessary additional funds. The operating agencies are expected to recognize this policy of making upward, as well as downward, adjustments when a final indirect cost rate is established, and to adopt appropriate procedures to give effect to this policy.

The HEW negotiator tries to ascertain the reasonableness and equity of the overhead pools and allocations, and reach an indirect cost rate which is acceptable to both the Government and the grantee. In other words, the negotiators determine the validity of the indirect cost rates proposed by the grantees, but they do not determine policy for reimbursement of indirect costs. Determination that research grants will pay full overhead at the negotiated rate, or that training grants will pay overhead only to a maximum of 8 percent of total direct costs, for example, are policy matters not under the control of the negotiators.

Once the rate is established, the grantor agency applies its own policies in reimbursing indirect costs. Thus, the Department of Defense allows independent research and development costs, while HEW will not allow such costs. Likewise, SRS limits indirect cost reimbursement on its research and training center projects to a maximum of 15 percent of total direct costs.

In addition, individual program managers or awarding agencies may refuse to pay any indirect costs to grantees or contractors, or at least they may resist such payment and try to influence the grantee to waive some or all of the allowable indirect cost reimbursement.

The negotiators are not efficiency experts, and they do not engage in management studies of the grantee institution. While the HEW negotiators and auditors try to screen the overhead pools to eliminate unallowable costs, and while they may infrequently question the reasonableness of a specific amount, they are not primarily in the area of trying to reduce or control overhead costs.

V. INDIRECT COST REIMBURSEMENT

In the early stages of this study, the Investigative Staff requested HEW to furnish information showing the dollar amount of overhead reimbursed to its grantees and contractors in the last 5 years. The Investigative Staff was advised thet HEW does not maintain any such information on a department-wide basis. Thereafter, at the request of the Investigative Staff, the Director of the Division of Financial Management Standards and Procedures, Office of the Assistant Secretary, Comptroller, circularized the various operating agencies of HEW. The agencies were requested to advise whether or not any or all of the information was available, and, if not, the feasibility of obtaining and furnishing it.

Replies received from each HEW operating agency disclosed that none could furnish all the requested information, and none except PHS could furnish any substantial amount of information.

OE "does not have a retrieval system to furnish the information requested. Approximately 50,000 official files would have to be individually reviewed. . . it is estimated that it would take from ten (10) to twelve (12) months of effort."

The information requested "is not readily available at NIE. . .six (6) man-months of effort would be required to review Contract and Grant folders and tabulate the data requested."

SRS could furnish indirect cost award amounts for FY 1974 from its grants information system. It estimated "that the task of determining actual indirect costs paid to individual grantees/contractors would require about 5,000-10,000 man hours for all SRS projects" for the past 5 years.

SSA could "provide data on contractor expenditures for direct and indirect cost for FY 70-74 for those SSA contracts administered by the Office of Research and Statistics. However, those contracts represent only a portion of SSA contract awards for research." The Property Management Branch, Office of Administration, which is responsible for the management of all SSA contract activity, "does not have the requested information available (and believes) that a herculean effort would be required to obtain such data."

The Office of the Assistant Secretary for Human Development has "no data. . available which would identify indirect costs paid to grantee/contractor institutions for fiscal years 1970 through 1974. To accumulate that kind of information. . .would require a grant by grant and contract by contract review of all awards made nationwide. . .a monumental task."

The Office of the Assistant Secretary for Planning and Evaluation has data available on indirect and direct costs for grants for FY 1974, the only year in which this office awarded grants. "The data on contract costs is not readily available. . .but would have to be developed by reviewing each grant and contract folder." This office estimated that the process would take from 6 to 8 weeks, "largely on overtime."

PHS was the only agency that could furnish a substantial amount of the requested information. PHS could provide direct and indirect costs for all fiscal years for grants awarded within headquarters offices, and for FYs 1973 and 1974 for grants awarded within regional offices. These data were never computerized for contracts, and retrieval would be impractical

NIH, through its Indirect Cost Management System, has readily available direct and indirect costs on all research grants awarded by NIH since FY 1968.

A. HEW Financial Assistance and Project Grants

Not only was the Investigative Staff unable to obtain information showing the amount of indirect costs paid to grantees and contractors for FYs 1970 through 1974, but HEW personnel also stated that it would be a major problem even to identify those grants and contracts which pay indirect costs.

The HEW Financial Assistance Reports provided a starting point. These reports classify the amounts of assistance into project grants, formula grants, and nongrant assistance. While these reports do not contain any information concerning indirect costs, they do list annual obligations for all HEW agencies. The schedule on the following page reflects the total HEW obligations by agency for FYs 1970 through 1974.

FINANCIAL ASSISTANCE BY AGENCY
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
FY 1970 - FY 1974
(000 OMITTED)

Agency	1970	1971	1972	1973	1974
Office of the Secretary	$ 406,595	$ 348,673	$ 369,608	$ 367,026	$ 714,247
Consumer Protection and Environmental Health Services	140,634	-	-	-	-
Environmental Health Services	-	49,521	-	-	-
Food and Drug Administration	-	73,016	87,440	7,694	4,516
Health Services and Mental Health Administration	900,716	1,017,345	1,713,521	1,690,804	704,525 a/
Health Resources Administration	-	-	-	-	354,789
Center for Disease Control	-	-	-	-	73,384
Alcohol, Drug Abuse, and Mental Health Administration	-	-	-	-	814,799
National Institutes of Health	1,191,532	1,267,433	808,197	1,749,919	2,397,211
Office of Education	4,024,578	4,398,612	4,812,017	5,326,442	5,386,287
National Institute of Education	-	-	-	-	63,828
Social and Rehabilitation Service	9,290,432	11,460,203	13,526,621	14,317,246	16,581,630
Social Security Administration	35,834,172	42,225,546	49,989,423	58,917,777	65,345,804
Special Institutions	47,646	111,578	100,033	[illegible],898	-
Total Assistance	$51,836,305	$60,951,927	$71,406,860	$82,382,806	$92,441,020
Departmental Administration	1,975,828	2,365,360	3,387,842	3,249,[illegible]50	3,895,961
Total HEW Obligations	$53,812,133	$63,317,287	$74,794,702	$85,631,956	$96,336,981

a/ In FY 1974, this is Health Services Administration.

The Financial Assistance Report program defines project grants as "outlays related to Federal Assistance for fixed or known periods, of specific projects or the delivery of specific services or products without liability for damages for failure to perform." Project grants include traineeships, experimental and demonstration grants, evaluation grants, planning grants, technical assistance grants, survey grants, construction grants, and unsolicited contractual agreements.

The Investigative Staff determined that project grants and contracts are the only forms of HEW financial assistance which pay significant amounts of indirect costs within the scope of this study. The following schedule shows by agency those amounts identified as project grants in the Financial Assistance Reports for FYs 1971 through 1974; the report for FY 1970 was not coded in the same manner as the reports for the other years:

(000 Omitted)

Agency	FY 1971	FY 1972	FY 1973	FY 1974
Public Health Service (excluding NIH)	$ 638,018	$1,342,339	$1,179,130	$1,471,592
National Institutes of Health	994,114	808,197	1,749,919	2,384,439
Office of Education	1,291,206	1,229,381	1,489,510	1,536,566
Social and Rehabilitation Service	371,072	463,139	196,365	145,561
All Other Agencies	460,251	458,422	517,346	950,776
Total HEW Project Grants and Contracts	$3,804,663	$4,301,478	$5,132,270	$6,488,934

Using the HEW Financial Assistance Reports as a basis, the Investigative Staff, through canvass of the operating agencies of HEW, attempted to establish categories of programs. The operating agencies of HEW were requested to review the list of programs funded by them, and classify the programs by the method used to reimburse indirect costs, such as, full reimbursement at the negotiated rate, limited reimbursement, or no indirect costs allowed.

The following table, based on the information furnished by the operating agencies of HEW, shows for FY 1973 and FY 1974 the categories of assistance eligible for full reimbursement of indirect costs at the negotiated rate, that eligible for limited reimbursement, and that not eligible for reimbursement.

Financial Assistance by Agency
Eligibility for Reimbursement of Overhead

(000 Omitted)

Agency	FY 1973			FY 1974		
	Full	Limited	None	Full	Limited	None
Office of the Secretary	-	-	$ 367,026	$ 46,313	-	$ 667,934
Food and Drug Administration	$ 2,610	$ 537	4,547	3,915	$ 601	-
Health Services and Mental Health Administration	760,975	94,633	835,196	-	-	-
Health Services Administration	-	-	-	449,169	37,251	218,105
Health Resources Administration	-	-	-	195,553	-	159,236
Center for Disease Control	-	-	-	72,184	1,200	-
Alcohol, Drug Abuse, and Mental Health Administration	-	-	-	397,168	142,121	275,510
National Institutes of Health	1,088,379	148,879	512,661	1,502,403	334,578	560,230
Office of Education	539,904	428,030	4,361,136	840,973	425,583	4,119,731
National Institute of Education	-	-	-	-	-	63,828
Social and Rehabilitation Service	134,497	42,794	14,182,544	97,250	23,981	16,460,399
Social Security Administration	99,205	-	58,773,355	174,211	-	65,171,593
Special Institutions	-	-	5,898	-	-	-
Totals	$2,625,570	$714,873	$79,042,363	$3,779,139	$965,315	$87,696,566

B. Public Health Service

PHS obligations for financial assistance for FYs 1970 through 1974 are shown on the following table.

Obligations for Financial Assistance
Public Health Service
FY 1970 - FY 1974
(000 Omitted)

Agency	1970	1971	1972	1973	1974
Consumer Protection and Environmental Health Services	$ 140,634	$ -	$ -	$ -	$ -
Environmental Health Services	-	49,521	-	-	-
Food and Drug Administration	-	73,016	87,440	7,694	4,536
Health Services and Mental Health Administration	900,716	1,017,345	1,713,521	1,690,804	-
Health Services Administration	-	-	-	-	704,525
Health Resources Administration	-	-	-	-	354,769
Center for Disease Control	-	-	-	-	73,384
Alcohol, Drug Abuse, and Mental Health Administration	-	-	-	-	814,799
National Institutes of Health	1,191,532	1,267,433	808,197	1,749,919	2,397,211
Totals	$2,232,882	$2,407,315	$2,609,158	$3,448,417	$4,349,224

PHS provided data showing grant awards for FYs 1970 through 1974, including a breakout of indirect costs. These data were obtained from 2 computerized information systems--the IMPAC system (Information for Management, Planning, Analysis, and Coordination) and the Grants Data System. The IMPAC system contains information on grants administered at the headquarters level of PHS; the Grants Data System contains information on grants administered at the regional level. Some PHS grants are split between the headquarters and regional levels. In such cases, if the majority of the money is awarded at the regional level, the information is contained in the Grants Data System; otherwise, the information is listed separately in the 2 systems.

There is no information or retrieval system in HEW to capture indirect costs paid on contracts. HEW Document 73.1 describes the data elements to be identified in its contract information systems. The elements to be identified relate primarily to the categories of contracts contained in the HEW Procurement Regulations, such as advertised, negotiated, small business, and the like. Indirect costs are not among the elements to be identified in the systems, so the only way to capture and tabulate such costs would be to review individual contracts.

From the IMPAC system, PHS furnished the information shown in the following table for grants administered at the headquarters level:

FY	Obligations	Indirect Costs	Percent
1970	$1,163,748,603	$153,927,154	13.2
1971	1,420,043,192	176,965,119	12.5
1972	1,676,085,707	217,906,268	13.0
1973	1,621,531,015	230,687,252	14.2
1974	1,895,014,019	301,652,557	15.9

The obligations in the foregoing table include obligations for programs which do not pay indirect costs, such as construction grants and fellowships, as well as grants which pay full or partial indirect costs. The table also includes supplemental obligations.

The following schedule shows a comparison of the increases in PHS obligations in the IMPAC system with the corresponding increases in indirect costs for FYs 1970 through 1974:

(000 Omitted)

	Total Costs			Indirect Costs		
		Increase Over Prior Year			Increase Over Prior Year	
FY	Obligations	Amount	Percent	Obligations	Amount	Percent
1970	$1,163,749	-	-	$153,927	-	-
1971	1,420,043	$256,294	22.0	176,965	$23,038	15.0
1972	1,676,086	256,043	18.0	217,906	63,979	36.2
1973	1,621,531	(54,555)	(3.3)	230,687	12,781	5.9
1974	1,895,014	273,483	16.9	301,653	70,966	30.8

This schedule shows that from FY 1970 to FY 1974, while total costs of PHS obligations in the IMPAC system increased by $731 million or 62.8 percent, indirect costs increased by $148 million, or 96.0 percent.

The aforementioned grant information for PHS does not include data contained in the Grants Data System.

The Grants Data System represents 3,696 grants for FY 1974 only, totaling $1,311,929,146, including $22,331,678 in indirect costs. Thus, 1.7 percent of the total dollars obligated at the regional level represents indirect costs.

PHS obligations and indirect costs for grants for FY 1974, combining the information in the IMPAC system and the Grants Data System are shown on the following page.

	Obligations	Indirect Costs	Percent
IMPAC System	$1,895,014,019	$301,652,557	15.9
Grants Data System	1,311,929,146	22,331,678	1.7
	$3,206,943,165	$323,984,235	10.1

The obligations shown in the IMPAC system for FY 1974 are composed of the obligations of the following agencies:

	Obligations	
	Amount	Percent
NIH	$1,322,031,699	69.8
Alcohol, Drug Abuse, and Mental Health Administration	319,710,707	16.9
Food and Drug Administration	4,500,000	.2
Center for Disease Control	3,734,000	.2
Health Resources Administration	245,037,613	12.9
Total	$1,895,014,019	100.0%

C. National Institutes of Health

Included in the PHS IMPAC system are obligations and indirect costs for NIH grants for FYs 1970 through 1974, as shown in the following table:

FY	Obligations	Indirect Costs	Percent
1970	$ 781,898,057	$123,928,892	15.8
1971	857,497,073	142,489,417	16.6
1972	1,032,877,163	175,279,237	17.0
1973	990,362,444	192,630,151	19.5
1974	1,322,031,699	253,335,510	19.2

This table, showing programs administered at the headquarters level, includes projects not paying indirect costs.

The PHS IMPAC system includes a category designated, "NIH Research Projects." The table on the following page shows the obligations and indirect costs for these NIH research projects for FYs 1970 through 1974.

FY	Obligations	Indirect Costs	Percent
1970	$354,873,036	$ 80,545,416	22.7
1971	386,333,690	90,362,841	23.4
1972	447,693,696	110,477,500	24.7
1973	464,721,196	119,133,341	25.6
1974	613,421,036	159,521,065	26.0

This table shows that from FY 1970 to FY 1974 obligations increased by $258.5 million or 72.8 percent, while during the same period indirect costs increased by $79.0 million or 98.1 percent.

The NIH Indirect Cost Management System accumulates indirect cost data for NIH research grants. This system is designed to reduce paperwork and facilitate computation of indirect costs. The system maintains current negotiated indirect cost rates for all grantees receiving NIH research grants. These rates are applied to the appropriate direct costs by the computer to calculate indirect cost awards to grantees. The Indirect Cost Management System has 92 separate base plans in its rate file, and 70 separate methods of treating fringe benefits.

Indirect Cost Management System reports for FY 1974 and FY 1973 show NIH research grants totaling $1,016,002,140 and $825,345,931, respectively. These amounts represent 12,792 and 11,400 awards, respectively.

The Investigative Staff selected 70 grantee institutions, receiving 6,004 grant awards in FY 1974, including the 27 largest recipients of NIH research grants, for comparison of indirect costs and effective indirect cost rates. The term, effective rate, is used in this report to show the ratio of indirect costs to direct costs, regardless of the negotiated rate and base. Included in the sampled institutions are all grantees with NIH research grants of over $10 million each in FY 1974. Also shown for these 27 grantees are their effective indirect cost rates.

The following schedules show the direct costs, indirect costs, and effective indirect cost rate for the 27 largest recipients of NIH research grants in FYs 1974 and 1973:

Direct Costs, Indirect Costs, and Effective Rate for 27 Largest Recipients of NIH Research Grants for FY 1974

Grantee	Direct Costs	Indirect Costs	Effective Rate
University of Washington	$ 20,814,850	$ 5,128,446	24.6%
Harvard University	18,541,327	6,958,316	37.5
University of California - Los Angeles	18,952,859	5,262,649	27.8
University of Wisconsin	17,309,492	5,535,673	32.0
Johns Hopkins University	17,573,773	4,732,644	26.9
University of California - San Francisco	17,066,670	5,028,394	29.5
Yale University	15,884,486	5,413,267	34.1
University of Pennsylvania	15,727,283	5,388,702	34.3
Stanford University	15,051,221	5,350,081	35.5
Columbia University	15,465,786	4,585,109	29.6
Washington University - St. Louis	13,953,626	5,505,132	39.5
Research Foundation of New York State University	12,805,771	4,373,948	34.2
Albert Einstein College of Medicine	11,544,318	4,946,201	42.8
University of Minnesota	13,118,395	3,236,399	24.7
Duke University	11,099,425	4,831,117	43.5
University of Chicago	11,521,092	3,458,260	30.0
University of Michigan	10,199,495	4,212,858	41.3
University of California - San Diego	10,003,206	2,892,505	28.9
New York University Medical Center	10,454,565	2,319,414	22.2
University of California - Berkeley	9,720,854	2,766,848	28.5
Baylor College of Medicine	9,013,798	2,505,286	27.8
Sloan Kettering Institute	8,684,983	2,821,014	32.5
Massachusetts Institute of Technology	8,471,739	2,706,455	31.9
University of Iowa	7,917,982	2,525,960	31.9
Massachusetts General Hospital	8,205,476	2,015,280	24.6
University of Alabama	8,074,744	2,023,647	25.1
University of North Carolina	7,898,818	2,180,882	27.6
Total	$345,076,034	$108,704,487	31.5%

Direct Costs, Indirect Costs, and Effective Rate for 27 Largest Recipients of NIH Research Grants for FY 1973

Grantee	Direct Costs	Indirect Costs	Effective Rate
University of Washington	$ 16,567,139	$ 3,979,725	24.0%
Harvard University	17,018,684	5,838,363	34.3
University of California - Los Angeles	13,739,833	4,167,737	30.3
University of Wisconsin	15,251,405	4,646,101	30.5
Johns Hopkins University	15,232,313	3,735,372	24.5
University of California - San Francisco	14,356,559	3,985,697	27.8
Yale University	12,753,677	4,048,395	31.7
University of Pennsylvania	12,937,175	2,713,783	21.0
Stanford University	11,781,593	4,090,120	34.7
Columbia University	13,370,179	3,503,592	26.2
Washington University - St. Louis	11,637,205	4,179,723	35.9
Research Foundation of New York State University	9,920,438	2,851,876	28.7
Albert Einstein College of Medicine	10,694,149	4,557,552	42.6
University of Minnesota	11,384,549	2,825,592	24.8
Duke University	9,869,080	3,869,052	39.2
University of Chicago	8,625,752	2,430,768	28.2
University of Michigan	8,645,055	3,746,108	43.3
University of California - San Diego	7,711,170	2,237,525	29.0
New York University Medical Center	8,925,307	2,043,218	22.9
University of California - Berkeley	7,979,716	2,494,888	31.3
Baylor College of Medicine	7,850,068	2,281,461	29.1
Sloan Kettering Institute	6,798,491	2,241,051	33.0
Massachusetts Institute of Technology	6,831,824	1,968,285	28.8
University of Iowa	6,138,209	2,010,431	32.8
Massachusetts General Hospital	5,959,343	1,612,425	27.1
University of Alabama	7,281,170	1,522,538	20.9
University of North Carolina	6,679,048	1,874,259	28.1
Total	$285,939,301	$85,455,637	29.9%

The grants to the 70 sampled institutions in FY 1974 totaled $591.5 million or 58.2 percent of the NIH research grants for that year. The grants in the FY 1973 sample totaled $480.9 million or 58.3 percent.

The indirect cost rate negotiated between the cognizant Federal agency and the grantee institutions is an overall rate applicable to all federally sponsored projects at that institution. The rate is applied to the direct cost base of each individual project to arrive at the amount of overhead reimbursed for the project. The amounts shown in the foregoing tables represent total overhead payments to the 27 grantee institutions for the periods involved. The totals do not in themselves show the variations which may exist between overhead payments for individual projects at an institution, so the Investigative Staff made an analysis of a small number of individual grants to a single grantee to show these variations.

The Massachusetts Institute of Technology, Cambridge, Massachusetts (MIT), is among the 27 colleges and universities receiving the largest amount of grants and contracts from NIH. For FY 1974, this institution received a total of $11 million in research grants from NIH, including indirect costs.

The on-campus research indirect cost rate for MIT for FY 1974 was 58 percent of direct salaries and wages including vacation, holiday, and sick pay, overtime premium pay, and jury time.

An analysis was made of selected research grants awarded to MIT in FY 1974 by the National Cancer Institute of NIH. The analysis was made to show the relationship between the actual negotiated indirect cost rate (58 percent) with the effective rate (indirect costs as a percentage of direct costs) and the indirect costs expressed as a percentage of total costs.

The data for the selected grants is shown on the following page.

Direct Costs	Base a/	Indirect Costs	Effective Rate	Total Costs	Indirect Costs as Percent of Total Costs
$ 80,318	$ 46,400	$ 26,912	33.5%	$ 107,230	25.1%
43,844	14,837	8,605	19.6	52,449	16.4
41,562	22,492	13,045	31.4	54,607	23.9
24,861	24,861	14,419	58.0	39,280	36.7
27,555	15,106	8,763	31.8	36,318	24.1
24,871	17,725	10,281	41.3	35,152	29.2
180,227	90,087	52,250	29.0	232,477	22.5
221,850	118,228	68,572	30.9	290,422	23.6
28,317	17,414	10,100	35.7	38,417	26.3
96,464	53,421	30,984	32.1	127,448	24.3
88,834	50,812	29,471	33.2	118,305	24.9
88,578	35,922	20,835	23.5	109,413	19.0
74,317	51,138	29,660	39.9	103,977	28.5
$1,021,598	$558,445	$323,897	31.7%	$1,345,495	24.1%

a/ Amount of salaries and wages included in total direct costs.

This table shows that the negotiated rate bears little resemblance to either the effective rate or the percentage of total costs represented by indirect costs. The effective rate for each grant depends on the amount of direct salaries and wages that represent the base. The effective rate for the selected grants varied from 19.6 percent to 58.0 percent, the latter representing a grant where the direct costs consisted solely of salaries and wages. The effective rate for the selected grants is 31.7 percent.

Expressed as a percentage of total costs, the selected grants had indirect costs ranging from 16.4 percent to 36.7 percent, with the ratio for all grants being 24.1 percent. This latter percentage closely approximates the ratio for all research grants in the NIH Indirect Cost Management System.

It is evident from the foregoing table that discussion of an indirect cost rate is meaningless without knowing the elements which constitute the base and the dollar amounts attached to these elements which are included in the direct costs.

In view of the lack of comparability of indirect cost rates, the Investigative Staff was unable to develop any meaningful comparison between overhead payments to universities versus all other grantees and contractors on the basis of rates. Accordingly, the Investigative Staff made a comparison of direct and indirect costs awarded by NIH in FY 1974 to 15 colleges and universities and to 15 other institutions. The 30 institutions in this comparison were selected from the NIH Indirect Cost Management System. The effective indirect cost rate for the 15 colleges and universities was 30.9 percent, while for the 15 other institutions the effective rate was 34.5 percent. At the colleges and universities, indirect costs represented 23.6 percent of the total grants while at the other institutions indirect costs represented 25.7 percent of the total grants.

A similar comparison of the same 30 institutions for FY 1973 reflected that the 15 colleges and universities had a combined effective indirect cost rate of 28.7 percent compared to an effective indirect cost rate of 32.0 percent for the other institutions.

Even this comparison does not depict accurately the level of overhead payments to universities compared to payments to other grantees and contractors. In the opinion of the Investigative Staff, it is the type of grant, rather than the type of grantee, which shows the disparity of overhead payments. In the case of NIH research grants processed through the Indirect Cost Management System, overhead payments awarded with indirect costs computed at the negotiated indirect cost rate appear to have a higher effective rate than other grants which are subject to a fiscal review during which HEW personnel and representatives of grantees may agree on reimbursement of overhead at levels less than the full rate. Of even greater significance in such a comparison appears to be the number of training grants awarded outside the Indirect Cost Management System. The grants, carrying an 8 percent limitation, reduce the average effective rate substantially.

The following table shows, for FYs 1970 through 1974, the total dollars awarded and the related indirect costs for NIH research grants:

FY	Total Dollars Awarded	Indirect Costs	Percentage of Total Award	Percent of Increase Over Previous Year
1970	$482,764,700	$107,198,300	22.20%	- %
1971	557,745,800	126,005,700	22.59	1.76
1972	675,272,900	159,649,600	23.64	4.65
1973	720,771,600	179,038,000	24.84	5.08
1974	893,480,000	232,039,900	25.97	4.55

This table shows that while the total dollars awarded increased by $410.7 million, or 85.1 percent, from FY 1970 to FY 1974, indirect costs during the same period increased by $124.8 million or 116.4 percent. As a percentage of the total award, indirect costs increased from 22.20 percent in FY 1970 to 25.97 percent in FY 1974, an increase of 16.98 percent.

The figures shown in the preceding table are for NIH research grants awarded by 10 institutes, all of which pay indirect costs at the negotiated rate. Not included are the same data for 3 other components of NIH: the National Library of Medicine, the Bureau of Health Manpower, and the Division of Research Resources. The awards for these 3 components are not all eligible for indirect costs, and some of the awards that pay indirect costs do so at a rate lower than the negotiated rate.

The following table shows, for FYs 1970 through 1974, the dollars awarded and the related indirect costs for the 3 components of NIH not included in the preceding table:

(000 Omitted)

FY	Total Dollars Awarded	Indirect Costs	Indirect Costs as Percentage of Total Award	Percent of Increase Over Prior Year
1970	$482,765	$107,198	22.2%	-
1971	557,746	126,006	22.6	1.8%
1972	808,107	166,243	20.6	(8.8)
1973	799,665	185,587	23.2	12.6
1974	985,738	240,191	24.4	5.2

For these 3 components of NIH, the total awards increased by $502.9 million, or 104.2 percent, from FY 1970 to FY 1974, while indirect costs for the same period increased by $132.9 million, or 124.1 percent. As a percentage of the total award, indirect costs increased from 22.2 percent in FY 1970 to 24.4 percent in FY 1974, an increase of 9.9 percent.

For FYs 1973 and 1974, the Indirect Cost Management System reports show the total direct costs and total indirect costs awarded for all NIH research grants, including the grants of the 10 institutes and the 3 other components shown in the preceding tables. The following schedule tabulates these costs, and shows both the indirect costs as a percentage of the total costs, and the effective indirect cost rate (indirect costs as a percentage of direct costs).

FY	Number of Awards	Direct Costs	Indirect Costs	Indirect Costs as Percentage of Total Costs	Effective Rate
1973	11,408	$639,759,000	$185,587,000	22.5%	29.0%
1974	12,792	776,611,000	240,191,000	23.6	30.9

D. Social and Rehabilitation Service

SRS provided a computer printout listing project grants, and some research and development contracts, for FY 1974. This listing showed direct and indirect costs as follows:

Direct Costs	Indirect Costs	Total	Indirect Costs as Percent of Total
$122,865,717	$4,639,692	$127,505,409	3.6%

SRS could not provide a tabulation of indirect costs for any years prior to FY 1974.

The FY 1974 tabulation is arranged by programs. A review of the individual projects in each program disclosed that many grantees did not receive indirect cost reimbursement, although grantees within the same program did receive such reimbursement.

For example, the "Child Welfare Research" program lists 10 separate awards in 5 regions. Only 2 grantees, both in California, received indirect costs. The indirect cost reimbursement for these 2 grantee institutions was 25.5 percent and 27.1 percent, respectively, of their total grants, while the program consisted of total grants of $1,194,073, with indirect costs of $118,634, or 9.9 percent.

Another program, "Demonstration (Section 1115)," consisted of 28 separate awards totaling $1,334,089, and indirect costs of $703, or .05 percent. Only 1 grantee in this program received indirect costs at the training grant rate of 8 percent; the remaining 27 projects did not receive any indirect cost reimbursement.

The "MR Hospital Improvement" program involved 93 separate projects totaling $5,565,194 with corresponding indirect costs of $153,070, or 2.8 percent. Within this program, 22 grantees were awarded indirect costs; the other 71 grantees did not receive indirect cost reimbursement.

The "Rehabilitation Research and Training Centers" program was composed of 19 separate projects totaling $10,573,600, with indirect costs of $712,885 or 6.7 percent. Ten of the grantees did not receive any indirect cost reimbursement. However, the other 9 grantees received indirect costs totaling $712,885 on total grants of $4,048,200, or 17.6 percent.

The "RSA-Long Term" program, consisting of 207 awards totaling $12,042,197, with total indirect costs of $592,462, or 4.9 percent, had 24 awards without indirect costs. The 24 awards without indirect costs totaled $1,244,449. The 183 awards with indirect costs, totaling $10,797,748, received indirect costs of $592,462, or 5.5 percent.

The "RSA-Expansion" program totaled $32,159,835, with indirect costs of $228,771, or .7 percent. This program had 161 awards. Only 14 grantees received indirect costs; the remaining 147 awards did not include indirect costs.

Assuming the accuracy of the data listed above, SRS has been very successful in reducing the amounts it pays for overhead by having grantees waive reimbursement for indirect costs.

E. Social Security Administration

The Office of Research and Statistics of SSA provided a schedule detailing contracts for 47 projects during FYs 1970 through 1974. The schedule on the following page shows the total dollars obligated each fiscal year and the corresponding indirect costs.

FY	Direct Costs	Indirect Costs	Total	Indirect Costs as Percent of Total
1970	$ 794,616	$ 177,672	$ 972,288	18.3%
1971	584,247	226,372	810,619	27.9
1972	168,806	72,867	241,673	30.2
1973	1,730,667	667,796	2,398,463	27.8
1974	3,973,182	1,097,652	5,070,834	21.6

As set out in Section V-A of this report, SSA had obligations of $99.2 million and $174.2 million eligible for full indirect cost reimbursement in FYs 1973 and 1974, respectively. The $2.4 million and $5.1 million in the schedule shown above represent only 2.4 percent and 2.9 percent, respectively, of the amounts eligible for full reimbursement of indirect costs for those years.

F. Office of Education

OE was able to provide the total number and amount of contracts and project grants administered at the headquarters level for FY 1974. During this period, OE headquarters awarded 8,396 grants totaling $561.3 million and 540 contracts, totaling $80.0 million.

According to the HEW Financial Assistance Reports, OE obligated approximately $5.4 billion during FY 1974, of which approximately $1.5 billion represented project grants and contracts. According to information furnished by OE, approximately $1.3 billion represents project grants and contracts eligible for reimbursement of indirect costs, while approximately $4.1 billion represents awards paying no indirect costs.

OE was unable to provide a breakout of indirect costs associated with its project grants and contracts.

G. National Institute of Education

NIE came into being on August 1, 1972. NIE is part of the Education Division of HEW, reporting to the Assistant Secretary for Education. NIE began with transfer from OE of about 30 people and $90 million worth of the programs. The programs transferred from OE included primarily career education model development, experimental schools, researcher training, regional education laboratories, and research and development centers.

NIE was unable to furnish information as to the amounts of indirect costs paid on its grants and contracts.

H. Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (OASPE) of HEW has awarded grants only since FY 1974. The grants awarded by OASPE are those authorized by Section 232 of the Economic Opportunity Act transferred to HEW from the Office of Economic Opportunity. The grantees of awards from OASPE may claim reimbursement of indirect costs at the negotiated rate.

OASPE does not maintain any tabulations of, or any retrieval system to identify, the amount of indirect costs awarded on any of its grants. There were only 42 such grants awarded in FY 1974, of which 19 were centralized. Because of the small number of centralized grants, OASPE was able to obtain the amount of indirect costs of each grant from the individual files. The remaining 23 grants were decentralized and administered by the regional offices, and it was not practicable to determine the amount of indirect costs awarded on these grants.

OASPE has awarded contracts prior to FY 1974. These contracts were for program evaluation. Again, OASPE does not have any tabulation of the amount of indirect costs paid on these contracts, and it was not practical to identify and review the individual contracts to obtain this information.

The table on the following page shows the direct and indirect costs of the 19 centralized OASPE grants in FY 1974.

Direct Costs	Indirect Costs	Total	Indirect Costs as Percent of Total
$9,911,370	$1,594,050	$11,505,420	13.9%

I. Review of Grantee Files

The difficulty encountered by the Investigative Staff in making any meaningful comparisons among grantees and contractors is illustrated by specific situations found in various grantee files.

The indirect cost rate for all campuses of the University of California system is negotiated on a state-wide basis. The 1973 on-site indirect cost rate for research for all campuses was 51.5 percent of direct salaries and wages, including vacation, holiday, and sick pay, but excluding other fringe benefits. In 1974, the rate was changed to 34.2 percent of total direct cost less expenditures over $50,000 for single purchases from third parties of hospitalizations and other services related to patient care, and expenditures for alterations and renovations and equipment.

From 1973 to 1974, the total NIH research cost at 4 campuses of the University of California--Los Angeles, San Francisco, San Diego, and Berkeley--increased from $56.7 to $71.7 million, or 26.5 percent. During the same period those costs identified as indirect increased from $12.9 million to $16.0 million, or 24.0 percent.

In 1973, indirect costs were 22.7 percent of the total costs, while in 1974, with a different base and rate, indirect costs were 22.3 percent of total costs.

In 1973, the effective indirect cost rate, or ratio of indirect costs to total direct costs, was 29.4 percent, compared to the negotiated rate of 51.5 percent of direct salaries and wages. In 1974, the effective rate was 28.7 percent, compared to the negotiated rate of 34.2 percent of total allowable direct costs.

Thus, despite a change in base and rate at the University of California between 1973 and 1974, the effective rate changed only from 29.4 percent to 28.7 percent. Even with this decrease in effective rate, the actual amount of indirect costs for the 4 campuses increased from $12.9 million to $16.0 million.

The Investigative Staff made an effort to isolate significant elements of indirect costs contributing to the general increase in the level of overhead reimbursement by HEW. While numerous instances were found in various grantee files, an example at 1 small institution illustrates the effect of the current economic environment on overhead. The indirect cost rate at Northeast Louisiana University increased from 33 percent in FY 1969 to 42 percent in FY 1974; this translates to an increase of somewhat over 27 percent in the rate. A review of the items in the indirect cost pool for this period disclosed increases of approximately 60 percent in retirement plan costs, 40 percent in utility costs, and 38.5 percent in auditing service costs. Other files disclosed increases resulting from such diverse items as additional security services, higher pay for nonprofessional employees, extensive repairs to the air conditioning system, and rented parking space for employees.

Although Federal agencies may establish ceilings on indirect costs allowed on their various programs, a grantee with some ingenuity can still recover its indirect costs. For example, the Economic Opportunity Board of Clark County, Nevada, a community action agency, receives grants from several Federal agencies, and the various agencies have different regulations covering reimbursement of indirect costs. The Board has a provisional indirect cost rate of 12.5 percent based on total direct costs less equipment and other capital expenditures. This rate was effective from January 1, 1974, until amended. The grantee has proposed a new rate of 13.6 percent on the same base, this proposal was in process at the time the Investigative Staff reviewed this file.

In grants to the Economic Opportunity Board of Clark County, HEW accepted and paid the negotiated indirect cost rate on its alcoholism programs. However, another Federal department would not pay at the negotiated rate, but would negotiate amounts it would pay for administrative costs and include these amounts as direct cost items. A different Federal agency would not pay indirect costs at the negotiated rate but would allow inclusion of such items as direct costs if they could be identified specifically with its projects. Still another Federal agency paid no indirect costs.

As a result of the foregoing circumstances, the grantee adopted the practice of allocating its indirect costs to the programs which allowed recovery. As an example, the grantee allocated 89 percent of the salary of an accountant to the "Head Start" program and 11 percent to the Emergency School Aid Act program. Such inconsistency obviously defeats any effort to control overhead costs or to allocate such costs equitably to sponsored programs.

A 1-year budget for a family planning grant application submitted to a regional office of PHS by a nonprofit organization requested an award of $60,000. No indirect costs were shown on the application, although the grantee had an established indirect cost rate of 15 percent. The submission then was revised as shown on the following page.

Direct Item	Original Submission	Revised Submission	Change
Personal services	$48,279	$40,360	- $7,919
Travel	3,000	2,500	- 500
Supplies	2,521	3,106	+ 585
	Net Change (direct costs)		- $7,834

The budget as revised and the grant as awarded then showed costs as follows:

$52,174	total direct costs
7,826	indirect costs (15% of $52,174)
$60,000	amount of grant

This grant illustrates vividly the futility of any effort to determine the amount of overhead paid by HEW on its grants under the existing system. The classification of costs as direct or indirect can be an exercise in semantics. In this illustration, the total award remains at $60,000, yet under the first budget submission, no indirect costs appear, while the revised budget shows indirect costs paid to the grantee at the authorized rate. There was no change in the project itself.

According to a representative of HEW who formerly was with the Office of Economic Opportunity (OEO), the latter agency considered establishing administratively a limitation of indirect costs which could be awarded to a grantee as 20 percent of total direct costs. The reaction to this proposal was immediate and adverse.

In particular, a group of the northeastern universities sent representatives to Washington. These representatives opposed the limitation and lobbied with both the executive and legislative branches of the Government. As a result, OEO was forced to abandon its efforts to establish a limitation.

VI. CONTROL OF OVERHEAD COSTS

As set out in Section V of this report, HEW was unable to identify the amount of dollars currently going into overhead payments to grantees and contractors except for a limited amount of data from PHS and SRS. In the absence of such information, HEW is hardly in a position to control overhead costs.

But even if HEW were able to identify overhead dollars for all grants and contracts, such information still would be inadequate for effective control because of the lack of uniform definitions and standards as to the elements which are identified as direct and indirect costs.

During the course of this study, the Investigative Staff did not identify any specific efforts being made by HEW to control the expansion of allowable overhead costs or to prevent the dollars currently going into overhead payments from increasing beyond the present level. While the general position of HEW is to support the policy of paying the full indirect costs applicable to its programs, there are in HEW factors and procedures which may have a substantial effect upon the amount of overhead paid to grantees and contractors.

A. Limitations on Overhead Reimbursement

It would seem that an obvious method to control overhead reimbursement would be to establish a ceiling. Until June 30, 1965, a statutory limit governed the recovery of indirect costs incurred by institutions performing research under Federal grants. In those instances in which it was determined that the institution's actual indirect cost rate exceeded the statutory limit, recovery was allowed only up to the statutory maximum. A detailed and precise determination of the actual indirect cost rate was not required if it could be readily determined that the limit had been exceeded.

Since July 1965, there has been no statutory limitation on the recovery of the indirect costs of research grants. There has been substituted for this limitation a legislative requirement that Federal grant funds may not be used to pay all the costs of any research grant at an institution. This requirement that grant recipients share in the costs of each project has been implemented administratively by HEW under policies which in certain cases continue to limit recovery of indirect costs.

HEW supports the policy of paying the full indirect costs applicable to its programs. However, because of legislative restrictions or budgetary constraints, it is necessary to limit the recovery of indirect costs in certain areas. Thus, indirect costs on training grants are limited to the lesser of actual indirect costs or 8 percent of total direct costs. SRS research and training center projects receive the lesser of actual indirect costs or 15 percent of direct costs. No indirect costs are awarded or paid on fellowships, construction grants, grants to individuals, or grants to institutions outside the territorial limits of the United States. Grants on which indirect costs are limited or prohibited by law are awarded in accordance with such restrictions.

In the study of variations in research indirect cost rates conducted by Peat, Marwick, Mitchell and Company, 5 institutions stated that they charged directly all costs that could be assigned reasonably to a research project. Any effort by these 5 universities to charge directly additional expenses would require refinement of their accounting system and probably the cost of such effort would exceed the benefits derived. All of the institutions indicated, however, that if a limitation were to be imposed on the recovery of indirect costs, the relationship between cost of such effort and benefit derived would be changed significantly, and they would reconsider their positions.

A statutory or administrative limitation on indirect cost reimbursement--for example, a limitation that indirect cost reimbursement may not exceed 20 percent of total direct costs--can be circumvented by a sophisticated grantee institution. This can be accomplished by classifying most of the costs as direct rather than as indirect. As an example, 2 institutions may have a rate based on direct salaries and wages. Each may have $100,000 in direct salaries and wages in connection with its grants, plus $50,000 in various other costs.

If Institution A puts all of its costs other than salaries and wages in its overhead, its costs and reimbursement would be computed as follows:

Costs

$100,000 direct salaries and wages
50,000 overhead

$150,000 total costs incurred

Reimbursement

$100,000 direct salaries and wages
20,000 based on 20 percent of total direct costs

$120,000 total reimbursement

Thus, Institution A would have $30,000 of unreimbursed costs in connection with the grant.

Institution B, on the other hand, might develop an accounting system to distribute much of its overhead to direct costs of the project--postage, duplicating, heat and light, power, payroll costs, and the like. It could, in theory, distribute $25,000 of its overhead to the direct cost of the project, leaving $25,000 in various other costs in its overhead pool. In such a case, the costs and reimbursements of Institution B would be computed as follows:

Costs

$100,000	direct salaries and wages
25,000	other direct costs
25,000	overhead
$150,000	total costs incurred

Reimbursement

$125,000	total direct costs
25,000	based on 20 percent of total direct costs
$150,060	total reimbursement

Thus, Institution B would have recovered all of its costs in connection with the grant.

While the foregoing example is somewhat oversimplified, in that Institution A would have some direct costs other than salaries and wages, it does illustrate the weakness of a specific limitation. And if Institution B is able to show that its allocation of costs is equitable, based on a solid theory consistently applied, its procedures are completely legal and acceptable under the regulations.

Under any limitation on reimbursement of indirect costs, only a precise definition of direct and indirect costs, uniformly applicable to all grantees, can prevent inequities to both the Government and the grantee.

HEW representatives contacted by the Investigative Staff during this study recognized that grantees may avoid the problem of recouping indirect costs by classifying as many expenses as possible as direct costs. A number of grant files reviewed by the Investigative Staff supported the fact that this is done.

For example, an SRS rehabilitation grant was awarded to the Allen County Association for the Retarded, Fort Wayne, Indiana. Although this grantee could have claimed overhead at the full negotiated rate, no indirect costs were requested. However, the proposed budget listed as direct costs a number of expense items which usually appear in the overhead pool, including housekeeping costs, laundry, heat, light, power, and lawn care. Similar classification of items normally considered overhead as direct costs were noted in other files, where grantees had an established indirect cost rate and were eligible for reimbursement of indirect costs.

The Emergency School Aid Act does not allow reimbursement of indirect costs, but does permit inclusion of supportive costs which can be directly identified with the project. Again, the Investigative Staff found that projects under this program included as direct supportive costs expenses generally considered overhead, such as a portion of the salaries and wages of auditors, payroll accountants, clerks, typists, and the like.

The standardization of indirect costs would aid the grantee institution as well as the Federal Government, since both would be in a better position to analyze the elements of indirect costs and the actual amount of indirect costs incurred by each grantee. The grantee would benefit by establishing an application rate which would serve as a standard. The grantee and the Federal Government would benefit by being able to analyze the over- and under-application of actual indirect costs. With standardization, it would be possible to compare the fiscal performance of various grantees.

B. Negotiation and Audit of Indirect Cost Rates

Most indirect cost agreements are negotiated on the basis of a desk review of proposals submitted by grantees or applicants for grants. Audits specifically aimed at indirect costs or indirect cost rate proposals are relatively rare.

The HEW Audit Agency is rarely able to conduct an audit of an organization more frequently than once every 3 years; in many cases, the cycle is substantially longer than 3 years. Most major universities are on a 3-year audit cycle, although some very large universities are audited annually.

When an audit of the proposal has been conducted, only a very cursory review of the proposal by the negotiator is necessary. In such cases, the major negotiation effort is aimed at resolving the audit findings not concurred in by the institution.

The study of variations in research indirect cost rates conducted by Peat, Marwick, Mitchell and Company disclosed that audit and negotiation of rates by the Government agencies did have a substantial effect on the indirect cost rate and the amount of indirect costs reimbursed to 2 of the institutions included in the study. In one case the rate was reduced by 14 percent and in the other case by 5 percent; these reductions decreased the reimbursements to the universities by $250,000 and $1 million, respectively.

The effect of an audit on the negotiation of an indirect cost rate was illustrated in several files reviewed by the Investigative Staff during the course of this study.

At the University of Michigan, for example, the HEW Audit Agency has a resident audit team, so the indirect cost rate usually is negotiated on the basis of an audit. The rates negotiated for FY 1975 were based on an audit of the FY 1973 operations of the University.

The following table shows, for FYs 1974 and 1975, the on-campus rates proposed by the University of Michigan, the rates recommended for acceptance by the HEW Audit Agency, and the rates actually negotiated:

	FY 1974		
	Proposed	Audit Recommendation	Negotiated
Research	60.3 %	56.1 %	58.2 %
Health Sciences	62.5	58.3	60.5
Educational Service Agreements	[illegible].0	89.4	90.2

	FY 1975		
	Proposed	Audit Recommendation	Negotiated
Research	65.2 %	61.2 %	62.2 %
Health Sciences	68.6	65.0	66.0
Educational Service Agreements	71.2	71.2	71.2

The rates recommended for acceptance by the HEW Audit Agency were arrived at by the elimination of certain costs deemed unallowable--use charges on equipment purchased with Federal funds, public relations and fund raising expenses, and administrative expenses reimbursed under Federal student aid programs--and by adjustments to certain allocations of allowable costs. No exceptions were made on the basis of unreasonableness of costs.

A single indirect cost rate is negotiated by HEW for all branches of the University of California system. There is a resident audit team at Berkeley, California, so negotiations with this huge complex of institutions has the advantage of audit support. The following table shows recent on-campus indirect cost rates proposed by the University, recommended for acceptance by the HEW Audit Agency, and the rate negotiated:

	Proposed	Audit Recommendation	Negotiated
Organized Research	59.80 %	48.92 %	49.0 %
Educational, Training and Public Service	61.88	54.32	60.0
University extension	27.02	28.66	22.0

The indirect cost base of the University at the time of that proposal was direct salaries and wages, including vacation, holiday, and sick pay, but excluding all other fringe benefits. Subsequently, the University of California has adopted a total direct cost base.

Another example of the effect of an audit on an indirect cost rate negotiation was found in the file of Brigham Young University, Provo, Utah. This University had a predetermined indirect cost rate of 44.5 percent for 1971-1973, and a final rate of 60.1 percent for 1974. The grantee then proposed a rate of 91.2 percent for the subsequent period. The grantee justified this large increase on the basis of detailed analyses of its equipment and space-use costs and of its research and faculty time. The HEW Audit Agency recommended a rate of 54 percent. The auditors questioned the use allowance proposed by the University for lack of records. The negotiators agreed to a rate of 60 percent, with the proviso that the use allowance must be fully documented for the next year or it will be disallowed.

An HEW negotiator pointed out to the Investigative Staff that while the negotiators and auditors are interested in eliminating improper or excessive overhead costs, the propriety of allocation of indirect costs is of greater significance. As an example, he pointed out that the elimination of an item of $50,000 for rare books at the University of California would have an insignificant effect on the amount of overhead reimbursed to that University. On the other hand, a reduction in the allocation of an overhead pool at the University of California system would have a substantial effect on the indirect cost reimbursement to that University, as 1 percent of the total direct costs of NIH research grants alone at 4 campuses in FY 1974 represents approximately $747,000.

The usual indirect cost audit is limited in scope and does not attempt to evaluate the efficiency of the institution or perform a cost reduction function. The auditors do try to evaluate the reasonableness and materiality of the costs, and the allocation of overhead pools. Nevertheless, the audits do on occasion result in findings which illustrate the possibility of the Government reimbursing grantees for obviously excessive and improper costs. The following example of such findings was brought to the attention of the Investigative Staff by an HEW Regional Comptroller.

The Education Commission of the States, with headquarters in Denver, Colorado, is a compact of the education departments of the 50 states. The organization has a current annual budget of approximately $6.6 million, of which approximately $6 million is received from OE. The Commission applied to HEW for an indirect cost rate. The HEW Audit Agency made an audit of the organization. The audit disclosed numerous items to which exceptions were taken, including large dinner and bar bills with no explanation as to why they were charged as an expense, per diem rates greatly in excess of Government standards, membership in a private club, and even beauty parlor charges. These items would have been included in overhead pools for allocation to Government grants and contracts.

The rate is under negotiation in HEW Region VIII. Whatever rate finally is agreed on, the negotiators at least have had the benefit of the audit findings.

The Investigative Staff certainly is not proposing that all indirect cost rate negotiations should have audit support. Obviously the extent of audit support must take into consideration such factors as the amount of Federal assistance received by the institution involved, the dollar amount which will result from the rate established, and past experience with the institution.

The Investigative Staff is of the opinion that the HEW Audit Agency should continue to concentrate its resources at the major institutions. In addition, the Audit Agency could extend the value of its findings and give more support to the negotiators by identifying problem areas and potential trends in indirect cost rates and by furnishing these findings to the negotiators.

C. Fiscal Review of Project Applications

When an application for an award is received from a prospective grantee or contractor, HEW personnel perform a fiscal review of the application and the proposed budget. Among other things, the HEW personnel review the direct costs listed in the proposed budget, and may negotiate changes in the direct costs. As to the indirect costs requested by the applicant, however, the fiscal review consists only in verifying that the applicant has an indirect cost rate agreement negotiated by the cognizant Federal agency. If the applicant has such a rate, the review consists only of verification of the rate and of the arithmetic of the computation of indirect costs. Where the applicant has a negotiated indirect cost rate, the awarding agency has no control over the amount of indirect costs which the grantee may receive. Regulations provide that the awarding agency may request negotiation of a special rate if the established rate appears inequitable to the grantee or to the Government; however, the Investigative Staff did not identify any instances in which a special rate was requested on such basis.

The Investigative Staff obtained 7 sample application forms used by PHS, OE, and SRS at the regional level. A review of these applications by the Investigative Staff disclosed that minimal information is required on the forms concerning indirect costs. At most the applicant is required to indicate whether he wishes to claim or waive reimbursement of indirect costs. If reimbursement is requested by the applicant, only the negotiated rate and base need be shown, and the arithmetical computation of base multiplied by rate.

The HEW personnel checking the application can verify the rate to the negotiation agreement, and can verify the arithmetic. However, the fiscal review does not provide any thorough review of the indirect costs of the project. The reviewer has no way of knowing what elements of costs constitute the base, nor does the reviewer have any practical method of determining that items of direct costs in the proposed budget are not included in the overhead pools on which the indirect cost rate was developed. The fiscal review depends largely on the accuracy and reliability of the information furnished by the grantee, although of course additional information may be obtained from the applicant during the review.

At the regional level, at least, the fiscal review does provide some control of indirect costs. Cost sharing represents one such method of control. Some of the HEW grant programs require the recipient to share part of the costs. Where there is such a requirement, grantees may, and often do, waive some or all of the indirect costs to which they otherwise are entitled, and use this amount for cost sharing. In a number of files reviewed by the Investigative Staff, the grantee applied its overhead reimbursement as some or all of its share of the cost of the project.

A significant limitation of indirect costs is accomplished at the regional level of HEW through budget constraints and program limitations. Despite the fact that it is the policy of HEW to pay the grantee for all allowable indirect costs, project officers in the regions may try to eliminate or at least reduce indirect costs paid to grantees.

Program personnel in PHS, SRS, and OE in all HEW Regional Offices visited by the Investigative Staff attested to the fact that grantees frequently will accept less than the full amount of indirect costs to which they are entitled. The operating budgets may not permit full funding of all programs, and the grantee has the choice of accepting less reimbursement of overhead or reducing the scope of the project. In some regions, program personnel frankly stated that if the grantee insisted on full reimbursement of overhead, they would deny the application. Other program personnel denied such coercion on applicants, but did say they would try to persuade the grantee to reduce its claim for overhead reimbursement.

Numerous instances of grantees waiving reimbursement of overhead, or accepting less than full reimbursement, were found in grantee files reviewed by the Investigative Staff. A few examples will illustrate this practice.

The Children's Hospital Medical Center, Boston, Massachusetts, has an institutional cost-sharing agreement with HEW. This nonprofit institution has a negotiated indirect cost rate of 33.43 percent of direct salaries and wages, less fringe benefits. On 2 grants from SRS in FY 1974, with direct costs totaling $196,790, the institution was entitled to indirect costs totaling $59,539. However, the Center elected to waive payment of indirect costs and used this amount as its share of the costs of the projects.

The Hogan Regional Center, Hathorne, Massachusetts, a unit of the Massachusetts Department of Mental Health, has a negotiated indirect cost rate of 50.5 percent of direct salaries and wages. This Center received a grant in FY 1974 from SRS in the amount of $25,000, of which $24,476 was total direct costs. Direct salaries and wages amounted to $20,675. Applying the negotiated rate to the base (50.5 percent x $20,675) would result in indirect costs of $10,441. The resulting budget would be as follows:

$20,675	Direct salaries and wages
3,801	Other direct costs
10,441	Indirect costs
$34,917	Total

However, fiscal constraints limited the maximum amount allowable to $25,000. The grantee then had the choice of reducing direct costs and so limiting the scope of the project, or reducing its claim for indirect costs. In this case, the grantee chose the latter course. The actual budget was then as follows:

$20,675	Direct salaries and wages
3,801	Other direct costs
524	Indirect costs claimed
$25,000	Total

The indirect costs claimed thus amount to 2.5 percent of the direct salaries and wages, [illegible] contrast to the 50.5 percent which is the negotiated rate.

D. Practices of Private Foundations

The Investigative Staff considered that the practices of the largest private foundations which award grants to colleges, universities, hospitals, and other nonprofit organizations might be of some relevance to this study. Accordingly, the Investigative Staff canvassed 26 of the largest foundations; 23 replies were received.

The practices of the foundations ranged from those that pay no indirect costs to those that make lump sum payments to grantees for which no detail of expenses is required.

One foundation reviews each proposal and attempts to distinguish between new costs (incremental costs), which it will pay, and those expenses that could be considered normal for ongoing operations, which it will not pay.

Another foundation usually disallows indirect costs on demonstration and research projects. The rationale is that if the project is important to the grantee institution, the grantee should demonstrate its commitment to the project by an in-kind or cash contribution. The foundation added that its "past experience has indicated that when there is no commitment on the part of the sponsoring agency, there is also little inclination on the part of that agency to assume responsibility for the continuation of the program even though evaluation of the program indicates it is worthy and merits continuation."

The Investigative Staff categorized the 23 foundation responses into 4 broad groups. Of the 23 foundations contacted, 10 pay indirect costs or do not limit the use of the grant funds; 8 will not pay, or seldom pay, indirect costs; 3 are special purpose funds without exposure to indirect costs; and 2 foundations will pay costs commonly referred to as indirect costs if they are specifically identified with the project.

E. Consideration of Alternatives

Indirect costs are real costs. When a Government-sponsored project is operated by a grant to a university or other type of recipient, if full indirect costs are not reimbursed by the Federal agency, the grantee is making a contribution to the project. Obviously, the grantee can afford to handle only as many of these projects as its resources will support.

On the other hand, benefits do accrue to recipients of Government grants and contracts, particularly to educational institutions receiving research grants.

Because the research becomes a part of the instructional resources of the university, the quality of instruction is improved and the prestige of the university is enhanced. Sponsored research enables a university to attract and retain qualified academic personnel, which in turn enhances its appeal to undergraduate and graduate students. Comparable benefits accrue to research-oriented nonprofit institutions and hospitals.

In theory, the Federal Government reimburses its grantees for indirect costs to defray the additional overhead expenses incurred by the grantee to support the sponsored project. In practice, this concept is subject to question.

The Far West Laboratory for Educational Research and Development, San Francisco, California, a nonprofit institution which is the recipient of large amounts of Federal grant funds, had a research indirect cost rate of 25.3 percent based on total direct costs less capital expenditures, and a special rate of 11.7 percent on the same base for certain workshops and seminars. These rates were established in an agreement dated June 7, 1974.

A cutback in Federal grant funds resulted in a reduction of approximately $1 million in the direct cost base of Far West for its FY 1974, with a resultant reduction in its recoupment of indirect costs. The institution had a cash flow problem because its established indirect cost rate was lower than its actual indirect costs experienced for the first 10 months of 1974 and projected through November.

In a request dated October 31, 1974, Far West requested an upward revision of its indirect cost rate. Based on the proposal submitted by the grantee, HEW established final rates of 27.7 percent and 15.0 percent for this institution for its fiscal year ended November 30, 1973, and provisional rates of 29.5 percent and 13.6 percent for its succeeding fiscal year.

This increase granted by HEW gives rise to doubts that indirect cost reimbursement is solely to pay increased overhead expenses resulting from Federal grants. Were this true, if Federal costs dropped, overhead should drop commensurately.

It is the opinion of the Investigative Staff that there is no incentive for a grantee to reduce overhead costs under the present system of establishing indirect cost rates. On the contrary, the system may encourage inefficiency, as the Federal Government will pay a share of the indirect costs of the grantee. This may result in an injustice to the Government, as the Government will pay for part of the cost of, for example, a more liberal retirement plan or a parking garage for the employees.

There is recognition of this lack of incentive among some HEW personnel. For example, the Cost Review and Assistance Division of HEW Region I recently submitted a paper outlining a new concept for paying indirect costs to grantees. The proposed new method contemplates the use of dollar incentives to stabilize and reduce indirect costs. The proposal is based on studies conducted in Region I which led to the conclusion that the present system does not offer any incentives to grantees to restrict the growth of overhead.

This paper pointed out that 2 methods have been used to reimburse grantees for indirect costs. Prior to 1967, the annual Appropriation Act for HEW limited reimbursement for indirect costs on research grants to 20 percent of direct costs; earlier limitations had been smaller. The practical effect of this limitation was to pay a flat rate, inasmuch as actual costs generally exceeded the statutory limitation. With the removal of the statutory limitation, the current system was initiated. In theory, the current system provides for full indirect cost recovery, as the negotiated indirect cost rate is designed to reimburse grantees for all allowable costs attributable to Federal grants unless specifically prohibited or limited by regulation or legislation.

The flat rate system in effect prior to 1967 did not really serve its intended objective. The grantees felt that the limitation prevented them from full recovery of their indirect costs, and, as a result, many of them resorted to "gamesmanship." By reclassifying as direct costs certain activities which might normally be included in overhead, such as utilities, maintenance, depreciation, and the like, the grantee was able to recover a substantial portion of its expenses as direct expenses. Such reclassification could reduce the indirect costs of the grantee to a point where they would be fully covered by the statutory limitation.

The current system reduces the likelihood that grantees will "play games" with indirect costs. The negotiated indirect cost rate provides for full recovery of allowable overhead expenses without the need for artificial reclassification of expenses. On the other hand, the current system does not provide any incentive for a grantee to reduce or limit overhead costs, as the Federal Government will absorb a substantial part of such costs.

The paper submitted by HEW Region I proposes an incentive system for payment of indirect costs, similar to the incentive provisions popular in some cost-type contracts. Under this proposed system, a target indirect cost rate would be established for the ensuing fiscal period. If the actual rate differs from the target rate, the grantee would be penalized for a higher rate by being required to absorb a portion of the excess, or rewarded for a lower rate by sharing in the savings.

The paper identifies several options for setting the target rate and for sharing the overrun or savings. For example, the target rate could be based on the most recent experienced rate of the institution, or an average indirect cost rate could be established for comparable institutions of the same type. The sharing feature could be on a 50-50 ratio or any other mutually agreeable ratio. In addition, a fixed maximum could be established beyond which the Government would not pay any part of the excessive indirect costs. The paper recognizes that other variables could be introduced in such an incentive rate plan.

If the target were to be established on the basis of an average indirect cost rate for comparable institutions, it would be necessary to mandate a rate base and define precisely which costs should be classified as direct and which as indirect.

Another concept was considered by California, the first State to implement the delegation of authority to the State departments of education to negotiate indirect cost rates for local education agencies.

In 1970, in an attempt to simplify the procedure, a concept was proposed to establish some standard rate or rates. The concept envisioned that the school districts in the State would be stratified by some standard or standards, such as student population or expenditures. A target rate would then be established each year for each stratum, based on a rotating sample; this would permit a rate to be established without checking every school district in the State every year. After the rate was established for each group, it would be applied to all school districts in that group. The effect of this procedure would be to reward efficient school districts which kept their overhead below the established rate, and to penalize inefficient districts which had higher overhead costs. This proposal never was adopted.

The U. S. Congress is not alone in its concern over the amount of grant funds going into overhead. The Investigative Staff learned in a regional office of HEW of an incident which occurred several years ago. The legislature of one of the States became concerned over the use of indirect costs by the State university. The university had attracted a substantial amount of Federal research grants, and consequently had received substantial amounts of money through reimbursement of indirect costs. The State legislature felt that the administration of the State university was using the indirect cost funds for unnecessary expenditures such as wall-to-wall carpeting for the residence of the president of the university and other "luxury" items. The legislature felt that it should have more control over the expenditures of the university, and proposed that all funds received as reimbursement of indirect cost should be turned over to the State treasury. The legislature would then have control of the use of the funds through the appropriations process. The university successfully resisted the move of the State legislature, and continues to receive and control the funds it is awarded for reimbursement of indirect costs.

The Commission on Government Procurement was created by Public Law 91-129 in November 1969 to study and recommend to Congress methods "to promote the economy, efficiency, and effectiveness" of procurement by the executive branch of the Federal Government. The report of this Commission was submitted to the President of the Senate and the Speaker of the House of Representatives on December 31, 1972.

The report of the Commission stated that because of the importance of Federal grant activities and the uncertainty of their relationships to procurement, a limited review of Federal grant-type assistance was conducted. As a result of its study, the Commission concluded that Federal grant-type activities are a vast and complex collection of assistance programs functioning in a variety of ways that are often inconsistent even for similar programs or projects. This situation generates confusion, frustration, uncertainty, ineffectiveness, and waste. The Commission traced this disarray to 3 basic causes:

1. Confusion of grant-type assistance relationships and transactions with procurement relationships and transactions.
2. Failure to recognize that there is more than one kind of grant-type relationship or transaction.
3. Lack of Government-wide guidance for Federal grant-type relationships and transactions.

The report of the Commission pointed out that enacting legislation to distinguish assistance from procurement by standardizing instruments to reflect types of relationships would be an important step in reducing the present confusion.

The Commission also identified a need for a system which would provide guidance on means and methods of carrying out in more effective and consistent ways the increasingly large number of Federal grant-type assistance programs.

To this end, the Commission urged the Office of Federal Procurement Policy to undertake or sponsor a study of the feasibility of developing a system of guidance for Federal assistance programs and periodically inform the Congress of the progress of this study. In the event that the Office of Federal Procurement Policy does institute a study of Federal assistance programs, it is the opinion of the Investigative Staff that the problem of indirect costs should be included in the agenda.

VII. RECOMMENDATIONS FOR CONSIDERATION BY THE COMMITTEE

The question as to whether or not the Federal Government should pay a part or all of the indirect costs of its grantees and contractors is a philosophic question which is not within the scope of this study. Certainly, however, this is a reasonable question, and the Investigative Staff believes that the grantors should review their concepts regarding how much of the general costs of a grantee or contractor should be borne by the Federal Government.

The question as to the amount of overhead which the Federal Government should reimburse to its grantees and contractors has been the subject of considerable study. Indirect costs are of concern to both grantors and grantees, particularly the academic community. There is no simple solution to the problem, and the Investigative Staff certainly can offer no panacea which will solve the problem overnight. However, the study disclosed a number of items which, in the opinion of the Investigative Staff, merit consideration by the Committee and by HEW.

In FY 1974, HEW spent approximately $6.5 billion for project grants and contracts which pay significant amounts of indirect costs. Yet HEW could provide information concerning the amounts of indirect costs associated with only some $3 billion, or less than half of the total. OE, with some $1.5 billion in project grants and contracts in FY 1974, was unable to furnish any information as to the amount of overhead included in this total.

It is the recommendation of the Investigative Staff that the Committee should insist that HEW provide information as to the amount of its grant dollars currently going into overhead. Certainly it should be possible for HEW to capture a substantial amount of this information from its existing information systems without setting up any complicated and expensive new systems. Concurrently, the Committee may desire to direct HEW to make a start toward including overhead costs in its contract information systems.

Once HEW has determined the amounts it is paying for overhead on its grants and contracts, they will be in a position to institute affirmative action to reduce overhead costs, or at least control the expansion of such costs.

It is further recommended that the Committee consider requesting the recently established Office of Federal Procurement Policy to include in its study of Federal assistance programs the whole problem of indirect costs on grants and assistance-type contracts. A study by that Office could cover all executive branch departments and agencies, and would not be limited in scope to HEW programs.

Even if HEW were able to identify overhead dollars for all grants and contracts, such information still would be inadequate for effective control because of the lack of uniform definitions and standards relative to classifying direct and indirect costs and in establishing bases for distribution of overhead.

The Investigative Staff suggests that the Committee may wish to request HEW to study the possibility of developing standard direct cost definitions and a single base for overhead distribution. Such definitions would require that certain expenses be considered direct costs; all other allowable expenses then would be included in indirect cost pools. By classifying specific cost elements as direct costs and causing all other allowable costs to be included in indirect cost pools, HEW program people would be able to compare indirect cost or supportive costs from one institution to another. In conjunction with the establishment of standard direct cost definitions, HEW should consider the establishment of a single base for applying indirect costs. Currently in the National Institutes of Health Indirect Cost Management System there are 92 separate base plans for applying indirect costs.

The Investigative Staff does not think that it is too much to ask of institutions receiving money from the Federal Government that they comply with such standards in presenting their financial information.

The Committee may wish to consider urging HEW to study the advisability and practicality of evaluating the efficiency and frugality of its grantees and contractors in order to eliminate wasteful practices and frills. While the provisions of OMB Circulars A-21 and A-87 define allowable costs and establish criteria as to reasonableness, they do not in themselves provide any incentive for reduction of overhead costs. On the contrary, a grantee receiving a large portion of its income from Federal sources may be prone to incur costs for such items as a more liberal retirement system or a parking garage for its employees, knowing that the Government will pick up a part of such costs through its reimbursement for overhead. The Investigative Staff did not identify any "should cost" studies by HEW of any of its grantees or contractors.

The HEW Audit Agency took exception to many items of costs incurred by an organization which receives approximately $6 million of its $6.6 million budget from OE. The exceptions included large dinner and bar bills, per diem rates greatly in excess of Government standards, and even beauty parlor charges. The Committee may wish to ask HEW to identify other instances of this nature, and to explain the measures taken by its indirect cost rate negotiators to preclude such potential abuses.

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Mr. YOUNG. I would like to point out that the present negotiations on indirect costs with the universities is in direct response to numerous audit reports. There is little use in doing audit reports until corrective action is taken.

There are several universities, as the audit reports reveal, who are reporting more than 100 percent overhead on given grant related salaries, and others who are transferring funds from one grant to another, after the grant has been closed. We have made these findings known to the universities, in my relationships with them, and what to do to correct these things, but the revisions in the cost principles are also aimed at correcting these abuses particularly where the regulations are not very clear.

GENERAL PROVISIONS

Mr. FLOOD. Well, let's talk about the general provisions. Now we have problems every year with the general provisions of our appropriation bills, so we would like you to provide us with a list of general provisions which appeared in the 1976 Education Appropriation Act and the Labor-HEW Appropriation Act, and tell us which ones you are proposing for inclusion in the 1977 appropriation act, and in any case where you propose that any one of those provisions be changed, or left out of the 1977 Act, we would like a paragraph or so of explanation at that point.

Secretary MATHEWS. Fine. We will be delighted to do that, Mr. Chairman, and, as a matter of fact, we are in the process of completing that now.

[The information follows:]

March 9, 1976

Disposition of General Provisions in the FY 1977
President's Budget

Description	Education Bill	HEW Bill	President's Budget	Comments
Prohibition of withholding SRS grants to States because of disapproval of their merit system	—	201	*	
Authorization for transfer of motor vehicles	—	202	—	The budget does not propose to continue this provision because the authority is not used
Prohibition against 100% Federal funding of research project grants	310	203	307	
Prohibition against collecting interest earned on grant funds prior to 1964	311	204	—	The budget does not propose to continue this provision because it is obsolete.
Requirement dealing with additional positions in the Washington area vis-a-vis the rest of the country	313	205	309	There is a subtle difference between these two provisions. The Eduction bill requires that the proportion of new positions in the Washington area not exceed the proportion of positions existing in FY 1966 The Labor-HEW bill merely requires that new positions in the Washington area may not cause the total poritions in Washington to exceed the proportion existing in FY 1966. The President's budget would continue the Education bill version.

* Included in President's budget, but unnumbered.

Description	Education Bill	HEW Bill	President's Budget	Comments
Miscellaneous provisions dealing with the Public Health Service	---	206	*	
Green "anti-busing" provision	314	207	310	
Green "anti-busing" provision	315	[illegible]08	311	
Byrd "anti-busing" provision	---	209	---	This is a new general provision which goes beyond existing law. P.L. 93-380 limited such transportation to the school next nearest the student's home.
Limitation on payments to profit-making consultant firms	307	---	---	This is not proposed to be continued because it constitutes an arbitrary ceiling. The reporting requirement remains and the Department has no objection to it.
Provision for lump sum grants to Special Institutions	312	---	308	
Provision for payment of consultants at not to exceed the rate for GS-18	301	401	*	
Salaries and expenses funds in bill available for uniforms or allowances	---	402	*	
Salaries and expenses funds in bill available for attendance at meetings	302	403	*	
Prohibition against use of funds for Civil Service Brard of Examiners	304	404	---	The budget proposed to delete this because it is obsolete.

* Included in President's budget, but unnumbered.

Description	Education Bill	HEW Bill	President's Budget	Comment
Anti-student riot provision	305	405	*	
Authorization to transfer unexpended balances for the same purpose	306	406	*	
Provision limiting funds to current fiscal year unless otherwise provided	303	407	*	The budget proposes to delete the last phrase because it was intended to facilitate the transition to the new fiscal year
Anti-propaganda provision	308	408	*	
Ninety percent SLUC limitation	309	409	—	The budget proposes deletion of this provision because it is inconsistent with the Public Building Amendments of 1972
Provision for the Secretary's representation expenses	—	410	*	
Provision requiring informed consent for human experimentation	—	411	*	

* Included in President's budget, but unnumbered.

BUSING

Mr. Flood. Now here's one. Sometime or other I am sure you have heard about this, busing.

Secretary Mathews. How do you spell that, Mr. Chairman?

Mr. Flood. I don't know, it's a matter of opinion. One of the general provisions gave us fits last fall, and I am referring to Section 209 of the Labor-HEW Appropriation Act. That's the so-called Byrd amendment, relating to busing. Now I would like to—you are sitting right there—so I would like to pin you down right now on this. Do you or don't you recommend we include this provision in the 1977 appropriation bill?

Secretary Mathews. Mr. Chairman, as you have just recited, Congress, in its wisdom, added this amendment to the appropriations bill. Congres acted on that bill, passed it, and it's now a matter of law by action of Congress. We are not making any proposal to you that you remove the Byrd amendment from the 1977 Appropriation.

As for the position of the administration on this general matter, I think it was last and best reflected in the debate and in the position that the administration took on H.R. 69 or the Esch amendment.

Mr. Flood. I am talking right now about this provision, the Byrd amendment, in the 1977 bill.

Secretary Mathews. We have no recommendation to make to you for its exclusion.

Mr. Flood. Let me ask you this: Has the Byrd amendment had any real effect upon HEW's enforcement of title VI Civil Rights Act?

Secretary Mathews. It's frankly too early to tell, Mr. Chairman, to give a definitive answer.

Mr. Flood. Well, what is the effect?

Secretary Mathews. I would say to you as a matter of opinion, from the Office of Civil Rights, they tell me that undoubtedly it will change what they can do, because the Byrd amendment is more restrictive in what it allows than H.R. 69 was.

But they do not feel that it will totally disrupt their efforts, but it will restrict them, which, of course, was the intent of that amendment.

LOCATION OF FACILITIES FOR NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH

Mr. Flood. Now, I want to mention something about the NIOSH lab facilities. I guess you have heard something about that.

Secretary Mathews. Right, sir.

Mr. Flood. This committee, as you know, directed the Department to study and to identify the best possible location for the National Institute for the Occupational Safety and Health Laboratory.

Secretary Mathews. Yes, sir.

Mr. Flood. And the report that we received back in December doesn't appear to support the decision to locate the laboratory in Cincinnati. Now, have you looked closely at this report and are you satisfied that the study clearly supports the conclusion?

Secretary Mathews. I have looked.

Mr. **Flood**. I am sure you have. Now, the study was confined to those cities which were aware of the possible relocation of the NIOSH, and which expressed an interest in having the facility in the community, thereby excluding many potential excellent cities, simply because they didn't get the word about the relocation.

Secretary **Mathews**. Mr. Chairman, I am familiar with this matter. My information is, as is yours, that some several years ago that this matter was raised as to the proper location, and a very exhaustive survey was made of this. Extensive debates were held within the Department, and my predecessor, Secretary Weinberger, some 2 years ago, made that decision after proper consultation and what he considered a thorough review of the alternatives open to him.

That decision, I would repeat, was made 2 years ago. I see no authority on my part to reopen that case or to change that decision, and I trust that I have reflected that to you in my correspondence of December. Moreover, not only was the decision made 2 years ago, but we are well on the road to implementing that decision, contracts have been let for architectural studies, and other decisions are made, so we are well in the process of implementing that decision.

Mr. **Flood**. Well, a very distinguished member of this committee, the gentleman from Wisconsin, Mr. Obey, has spent a great deal of time on this subject.

I will yield to that gentleman.

Mr. **Obey**. Thank you.

Mr. Chairman, I do appreciate this because, as the gentleman from Kansas knows, he, I, and Mr. Conte will be in the Foreign Operations markup this afternoon, a somewhat more controversial meeting than this is going to be this morning, I think.

I would just like to ask a series of quick questions, Mr. Secretary.

Secretary **Mathews**. Yes, sir.

Mr. **Obey**. The language which this committee included in the report last year asked you to prepare a full report on the various cities considered for location of the NIOSH facility, the basis for final site selection, the site and cost of the building to be constructed and the plans for improved working conditions for NIOSH employees in Cincinnati until the new facility is constructed.

Then, almost a full month before we finished the conference on the bill you sent this report. You sent us this report dated November 17, 1975. That report is based on the work of two site selection committees, is it not?

Secretary **Mathews**. Yes, sir.

Mr. **Obey**. The first one visited and reported on only those cities in communities where local residents were aware of a possible relocation of the Agency's lab facilities and extended an invitation to the Agency to visit their community.

Is that not right?

Secretary **Mathews**. That is correct, yes.

Mr. **Obey**. You indicated that it was quite an exhaustive study. Is it not correct that Dr. Key, who directed the study, who was at that time the Director of NIOSH, has indicated it was not an exhaustive study?

Secretary **Mathews**. I am not familiar with that allegation, and my report is taken from the assurances given me both in November and before by Dr. Cooper, who is the principal officer for health in the Department.

As I said, it seemed to me that this decision had been made some several years before I took office, and the only——

Mr. OBEY. That is right, the committee was aware of that and that is why they asked for a new report. Let me suggest I will send you Dr. Key's statement so you can be apprised of his views as to whether it was an exhaustive study or not.

Secretary MATHEWS. Yes. All right.

Mr. OBEY. Let me review what happened. The second site selection committee did not receive permission to go forward with the study until November 14, a Friday, and completed the report on November 17, a Monday. Isn't that in fact true?

Secretary MATHEWS. The second committee?

Mr. OBEY. This one, the blue one that you have in your hand.

Secretary MATHEWS. Well, this was pursuant to your language, which directed us to make a report on what——

Mr. OBEY. My office was told on the Thursday before the Friday to which I refer that there would be, in fact, no report. Then we were told the following day that there would be a report, that it was begun on Friday, and it was finished on Monday. That is pretty fast, isn't it?

Secretary MATHEWS. I don't have those details in my personal knowledge, and I would be reluctant to testify to them. But I believe that the people who prepared the report thought that they were conforming to the language which simply asks that they advise the Congress on what they had done. They did not think that they were under a mandate by that language to conduct a totally new study.

Mr. OBEY. Well, this committee was aware of the report that was done in 1973. We did not feel that we should spend $60 million to $70 million in taxpayers' money for a new building on the basis of that report. That is why we asked for a full report. That didn't mean, in my judgment, a weekend job.

Now, how many of the sites evaluated in this report were visited by your site selection committee?

Secretary MATHEWS. In 1973?

Mr. OBEY. No; this time around.

Secretary MATHEWS. Well, as I say, this report was not——

Mr. OBEY. We asked for a new report.

Secretary MATHEWS. Yes; but the language as we interpreted it later, does not call for us to redo the 1973 study.

Mr. OBEY. I wrote the language and I was in contact with your people and informed them fully as to what the intent was.

Secretary MATHEWS. Yes; there obviously is some misunderstanding on this point. But there was no sense from this particular language that it mandated a redoing of the 1973 study with the cost involved. The language, as I read it, says that we are simply——

Mr. OBEY. How many cities were visited by the first committee?

Secretary MATHEWS. In 1973?

Mr. OBEY. Yes.

Secretary MATHEWS. I don't have personal knowledge of that.

Mr. OBEY. There were two cities visited.

Secretary MATHEWS. Yes; if that is what the report says then I am sure that is accurate.

Mr. OBEY. Let me put things on the table because I have been accused by some people of wanting this thing moved to Madison, Wis. in my State. I don't represent the city of Madison. I don't believe that this is likely to be located in Madison under any circumstances. In my judgment, even after I read this report, I come to the conclusion that the people who wrote it much preferred some place like Ann Arbor, for instance, possibly even Atlanta (which I personally question).

Mr. FLOOD. Or Pittsburgh.

Mr. OBEY. Well, I wouldn't hold that against them. But my concern is simply this: I have been as concerned about the operations of NIOSH as any member of this committee. My concern is that that Agency work in the best way possible because it has a giant duty to perform. And one of the greatest concerns this committee has is the ability of the Institute to recruit. And, as you know, they have had some very serious recruiting problems.

Let me ask you, in every year, when we questioned CDC people and NIOSH and NIEHS people they say the Government can't compete with private enterprise in recruiting all of the specialized professionals we need in this field.

That's one of the reasons we can't recruit. Let me ask you this: Was there any labor force analysis made to determine the estimated number of physicians, industrial hygienists, engineers, chemists, biostatisticians available in each of the communities supposedly under consideration in this report?

Secretary MATHEWS. If it is reflected that such was done in that report, it was done. If such is not, and you are asking me an additional question, I will ask the people who are familiar with that to respond.

Mr. OBEY. My understanding is—I am trying to determine how much of a report this really is.

Secretary MATHEWS. It would occur to me it would be useful to you and certainly we will be delighted to cooperate if the report does not answer questions that you have, then we would be delighted to answer them.

Mr. OBEY. That is not the point. The report does not meet, in my judgment, and I think the judgment of the chairman, the report does not meet the minimum standards expected by this committee.

Secretary MATHEWS. Well, perhaps you could tell us what those standards are, and we can respond to them.

Mr. OBEY. Well, if you read the language, I am sure you will understand what they are. We asked for a new report and we didn't ask for a weekend summary of a 2-year-old report by a committee which only visited two cities in the country to determine what the best location for this facility was.

So, you do not know that any labor force analysis was made to determine the presence of the kinds of professionals I just indicated in any of the communities?

Secretary MATHEWS. I have no personal information for you other than in the report that was submitted.

Mr. OBEY. Was any attempt made to establish a ranking system for the medical schools for the public health and engineering schools in the various locations? Certainly some of them would be better than others.

Secretary **Mathews.** I believe that they—but they were, but you are asking me about a study done in 1973 of which I have no personal knowledge.

Mr. **Obey.** Well no, I am asking you about this new study.

Secretary **Mathews.** The new study was, again, simply to report to you the basis on which the 1973 decision was made.

Mr. **Obey.** So, in other words, there was no effort made to establish a ranking of any of those schools this time around.

Secretary **Mathews.** The new study was not a restudy of the issue. It was a report on the 1973—

Mr. **Obey.** I understand. And the answer to my question is "no". Right?

Secretary **Mathews.** Yes, but you have to understand that this study did not purport to do that. It did not purport to reopen the question.

RECRUITMENT FOR NIOSH VACANCIES

Mr. **Obey.** That's right, that's right, and that is one of the things the committee felt it should do. That is why I want to get on the record the fact that it was not.

Did you make any inquiries to determine the relative potential for recruitment, this time around I am talking about.

Secretary **Mathews.** We did not.

Mr. **Obey.** On graduates from those schools or the interests within the schools among both faculty and students for the problem of occupational health?

Secretary **Mathews.** We did nothing in that report other than report to you historically on the basis on which we made that decision in 1973.

Mr. **Obey.** I will ask you three other questions to which I am sure I will get the same answer.

Secretary **Mathews.** Yes, sir.

Mr. **Obey.** As I read this report, it doesn't even appear to me that Cincinnati is the clear favorite. As I indicated before, I think several other cities come out, appear to come out much higher.

Mr. **Flood.** If the gentleman will yield, it certainly is not the clear favorite of the people that are going to do the work.

Secretary **Mathews.** I would submit for your consideration, Mr. Chairman, that the problem that you have with employing pharmacologists and toxicologists is a problem that relates to the market for those people and the difficulties of securing them in general. I have no information that suggests to me that that problem is greater or lesser in any geographic location. It seems to be a general problem.

Mr. **Obey.** Don't you think that is the kind of question to which we should have an answer before we determine whether or not we will commit $60 million, $70 million, $80 million to a new building? Shouldn't we know, in fact, whether it would be easier to recruit in one city vis-a-vis another?

Secretary **Mathews.** Yes, sir.

Mr. **Obey.** The only directive, the only source that I can find for any instructions for this report seems to be former Secretary Weinberger's age old instruction to include in the criteria for location "the problem of moving NIOSH personnel and their families who have made Cincinnati their homes," in the words of the former Secretary. Are you aware of any studies by Government or industry that suggests that there is a strongly negative impact on the retention of key personnel staff when an institution moves from one locality to another?

Secretary MATHEWS. I am not personally familiar with any reports that would testify one way or the other on that point.

Mr. OBEY. In fact, aren't there studies that show just the opposite that it does not have an appreciable effect on key personnel?

Secretary MATHEWS. There may or may not be. As I say, I am not personally familiar with studies that would indicate one way or the other.

Mr. OBEY. Could I ask you then when could this committee expect to have the kind of report which we asked you for in our Appropriabill last year?

Secretary MATHEWS. We feel we have submitted such a report. If they do not answer questions that you feel are appropriate well, we would be delighted to.

Mr. OBEY. We didn't ask you to answer questions, we asked you to conduct a new report, or a new study.

Secretary MATHEWS. What you are saying is that your committee has set aside the decision on Cincinnati and has reopened the issue.

Mr. OBEY. We have set aside nothing. It is my position that I will be damned if I will vote for a dime for a new building for NIOSH until I know that Cincinnati is the right place to build it, based upon a new study. I think that's the position of a good many members of the subcommittee, because we have been talked to by some people who work at NIOSH who tell us that, in fact, Cincinnati is not a good place for recruitment, who tell us that there are many areas of the country which would give them a better opportunity to fill the slots which they are given each year, and to, in fact, expand their operation in a way which is going to be necessary if we are not only going to deal with the present law, but to deal with future requirements under things like a Toxic Substances Control Act, you name it.

That's the concern of this committee.

Secretary MATHEWS. Fine.

Mr. OBEY. And I frankly don't care if it goes right back to Cincinnati, if the evidence shows it belongs there.

Secretary MATHEWS. The position of the Department is that that issue was thoroughly examined in 1973, that you asked us to tell you the basis on which that decision was made, and we have given you a report on that.

Mr. OBEY. No, we did not, we asked you to review that decision.

Secretary MATHEWS. We did not so interpret the language of that report.

Mr. OBEY. Well, then I repeat myself. Will you conduct a new study?

Secretary MATHEWS. We will answer any question you have about the basis on which——

Mr. OBEY. That doesn't answer the question.

Mr. FLOOD. That doesn't answer the question. You are now confronted with an entirely new set of circumstances, I am sure, for the first time as the Secretary.

Secretary **Mathews.** Yes, but I do not feel at the present time that I have a basis to set aside Secretary Weinberger's decision of 1973.

Mr. **Flood.** Mr. Secretary Weinberger's decision of 1973?

Secretary **Mathews.** Yes, in 1973.

Mr. **Flood.** Yes, we know very well.

Secretary **Mathews.** This exact matter was, in effect, tried in 1973, all of the appropriate evidence and——

Mr. **Obey.** And you visited two cities, two cities. They listed 5 in the report, 3 of them were never even visited.

Secretary **Mathews.** Possibly they made such examinations as were necessary to satisfy them that over a range of cities, these five were sufficient.

Mr. **Obey.** Is that your definition of an exhaustive study?

Secretary **Mathews.** Yes.

Mr. **Obey.** You said earlier the earlier study was exhaustive. You don't think you should see the facilities and examine the other facilities in the community?

Secretary **Mathews.** I am saying Secretary Weinberger——

Mr. **Obey.** He is not the Secretary anymore.

Mr. **Flood.** Did you expect an examination of this kind this morning? Did you have any idea that you would be presented with a series of questions as you have just heard this morning?

Secretary **Mathews.** I was aware there was some disagreement over the Cincinnati location.

Mr. **Flood.** You have carefully stated things. Did you have any idea that you were going to be presented with the type of very pointed questions Mr. Obey has asked?

Secretary **Mathews.** Mr. Obey did not give me his questions in advance.

Mr. **Flood.** You have them now.

Secretary **Mathews.** I do.

My position is still as it was when I came in.

Mr. **Flood.** Is that so?

Mr. **Obey.** With all due respect, Mr. Chairman, the position of this Member is that in the absence of any new study there will be no support on my part for any new building at NIOSH at any time in the future until we have such a study, and I have been more active I think than anyone on the subcommittee in my supporting, financial support for NIOSH in the past.

Mr. **Flood.** That's right.

Secretary **Mathews.** I will most certainly consider every question you have put to me today and will ask that we be responsive to you on those questions. I think we owe that to you.

Mr. **Obey.** I am not asking questions. I am simply stating that I consider that anything less than the conducting of a new study to be an avoidance of the instructions given by this subcommittee to HEW.

Secretary **Mathews.** All I can say is we have not so interpreted your language. If you direct me differently, of course, we will be responsive to whatever the committee directs through the language of the House.

Mr. **Flood.** I would think out of an abundance of caution, since that seems to be your point of view, if for no other reason, you would very carefully do that.

Secretary **Mathews**. Yes. We will, as I say, we will most certainly.

Mr. **Flood**. You were nodding your head yes?

Secretary **Mathews**. We will most certainly consider the questions Congressman Obey has put to us today.

HEALTH BLOCK GRANT

Mr. **Flood**. Yes.

Now on the matter of health, Mr. Secretary, it's not my intent now to discuss the merits or demerits of the various legislative proposals that were in the President's budget, but I do have a question regarding this health block grant proposal.

Secretary **Mathews**. Fine.

Mr. **Flood**. One of the curious things about this business of shifting to block grants is that the budget proposes to eliminate the comprehensive health grants to States, the so-called 314(d) grants, you know.

Secretary **Mathews**. Yes, sir.

Mr. **Flood**. Now, if block grants are the wave of the future, then why in the world are you proposing to eliminate an existing block grant program? How do you put that together? It appears that HEW isn't so sure about the merits of the block grants.

Secretary **Mathews**. We are simply consolidating into a larger block in that case, and as for the matter of waiving the requirement for State participation, I think that it's interesting and perhaps instructive that before we had requirements on States for matching they were supplying about $13 out of every $100 for health care. After 10 years of matching requirement they are still supplying about $13 out of every $100.

Mr. **Flood**. What about the comprehensive health grants to States? Comprehensive health grants to States—a block grant?

Secretary **Mathews**. Right.

Mr. **Flood**. Do you knock that off?

Secretary **Mathews**. We are going to consolidate them into a larger block and they are duplicative of what we are doing in the larger block, so we are simply doing it on the larger scale.

Mr. **Flood**. Then there are block grants, and block grants, and some are better than others, apparently.

Secretary **Mathews**. Well, it is in that we are just proposing a larger one for it.

Mr. **Flood**. Right. There are small block grants and large block grants, there are going to be different kinds of block grants. There is not just one block grant from now on, despite the statements.

Secretary **Mathews**. Well, there is only one in health, there is one in education and one in social welfare, but we would take a smaller one in health and expand it into a much larger one so we would propose only one health block grant.

Mr. **Flood**. Well, we have an impression that members are going to examine these block grants very carefully.

PROPOSED CLOSING OF PHS HOSPITALS

Well, now, Mr. Secretary, you made reference to the Department's proposal to close eight of the Public Health Service hospitals.

Secretary **Mathews**. That's right.

Mr. Flood. And you said in your statement these hospitals are in areas where there are adequate community facilities now available to care for the current PHS patient load.

Secretary **Mathews.** Right.

Mr. Flood. Now you know, we have received a great deal of mail from many people stating that adequate hospital facilities do not exist in several of these areas. Now have you assured yourself in the communities involved that they have the capacity and they are prepared to absorb this added patient load?

Secretary **Mathews.** In the majority of the cases, in fact, in five of the cases there are excess beds in those communities and the presence of the Public Health hospitals in those communities is driving costs up.

That is, it is a negative factor in health costs and in all of the areas we have assured ourselves that there are adequate facilities for serving this population in as effective a way and at often less cost than we are now providing.

Mr. Flood. How do you explain this—I don't want to say "flood"—this deluge of mail, and protests, quite the diametric opposite of what you have just stated?

Secretary **Mathews.** I would explain it very easily. I am sure, and it would be very understandable, and I think you and I both would have some similar feelings if we were in those communities, that this represents a diminution of program in the community and no community will take that without some protest.

Mr. Flood. You think the protests are mere localisms and parochialisms and there is nothing else to them?

Secretary **Mathews.** I think the facts I have given you are substantial, that is in five of the communities there is excess capacity, in all of the communities there is capacity to take care of providing the necessary services and, in general, the services that you can provide to the beneficiaries, that you intended to provide to them, can be provided in a more efficient way than you are now doing.

SUPPLY VERSUS MALDISTRIBUTION OF HEALTH MANPOWER

Mr. Flood. Now you know, I followed very carefully, in your prepared statement, you mention that we have met our goal in expanding medical school enrollments.

Secretary **Matthews.** Fifty-seven percent in recent years.

Mr. Flood. And thus HEW now is going to shift your emphasis from increasing the supply of health care professionals and you are going to concentrate your efforts on redressing this imbalance.

Secretary **Mathews.** Right.

Mr. Flood. In specialty and geographic distribution.

Secretary **Mathews.** That is right.

Mr. Flood. Of course, we agree that we must address the maldistribution problem. But we are not sure that we have solved the supply problem. We are concerned with the data published by OMB which shows that by 1990, 27.6 percent of our active physicians will be foreign trained and that represents an increase of 4.8 percent over the 1975 level.

Now will you explain to us in the committee why this country is going to have a national policy that is going to call for over 25 percent of its doctors to be foreign trained?

Secretary MATHEWS. I don't believe that we are representing that we have a national policy of using foreign-trained doctors. I think we are simply reporting to you on a trend that has been observable for some time. That is that the practice of medicine in this country as compared to other countries is very profitable and lucrative.

So people move to this country in order to practice medicine.

Mr. FLOOD. I am not talking about moving in. I am talking about the fact that without increased medical school enrollments, the OMB figures are going to produce a set of circumstances that 25 percent of our doctors are going to be foreign trained.

Secretary MATHEWS. Of course, we are continuing to support capitation in the medical schools but we have reached the conclusion that the problem of supply and the problem of actually getting adequate care are two different problems.

That is, even with our increase in the number of physicians in the last several years we still have large bodies of our citizens who not only have no care but also who have decreasing opportunities for care. We feel like this is the critical problem. Certainly that has been my own personal experience. I find wherever I go that that is the critical problem.

Mr. FLOOD. Nobody is more up on the question of maldistribution of physicians than this committee has been, long before anybody downtown got interested in it.

Secretary MATHEWS. So we are continuing to support capitation which would allow the medical schools to increase their enrollments, but we are mandating that those dollars go to what we feel is the critical national priority.

Mr. FLOOD. Just so you know, we watched that long before any of you people did.

MAXIMUM ALLOWABLE COST REGULATIONS

Mr. FLOOD. Now on this matter of maximum allowable cost regulations again. You know what State I am from and you know what the problem is.

Secretary MATHEWS. Yes, sir, I do.

Mr. FLOOD. I understand that the Senate medical assistance program administrators representing the States of Pennsylvania, New Jersey, West Virginia, New Hampshire, Maine, have indicated that unless the effective date of these regulations is withdrawn—or I guess they mean delayed—it will create, now let me quote—

> Utter administrative chaos and unwanted additional program costs at a time when the majority of the States, especially those of large populations, are being forced to consider major program cutbacks due to budgetary deficits.

Furthermore, those States have expressed serious concern with respect to this mid-fiscal year. The mid-fiscal year implementation of the regulation is not in the Pennsylvania budget. It is not in their budget setup. These States simply have not budgeted the funds necessary to administer the MAC program. Have you considered the problem that

MAC creates in these particular States? Do you have a solution to their problem? If so, what is it?

Secretary MATHEWS. When I began to look at this program, the charge that I heard was that the program would not do what it was intended to do, that it would cost more, and that it would have an adverse effect on the drug industry.

Mr. FLOOD. They tell me that in Pennsylvania they have a contract program on this MAC business, that it is working very well. They like it very much, and it is very satisfactory. They can buy these drugs at the lowest costs. But it is not in their budget. You are coming in with a midyear operation.

Secretary MATHEWS. To accommodate those concerns that you described and others, I have taken an action which I described in the letter I sent yesterday, which would be to incorporate into our procedures what is in effect a constant monitoring of the impact of those regulations so that we could make a determination of what exactly they did.

Mr. FLOOD. I know, but they want to know what is magic about this April 26 date for the implementation of these regulations. Where did you get that, off the left-field wall? Evidently these States we are talking about are simply not ready to implement this program. What they want to know is why can't you wait until you can prove the soundness of the program before you implement these regulations?

Secretary MATHEWS. There are two questions involved here.

Mr. FLOOD. Have they brought this to your attention?

Secretary MATHEWS. I have met with innumerable groups on this issue. There are two questions involved here. One is whether the regulations should be delayed or in effect abandoned until it can be absolutely proven that they will do what they said they will do; that is, whether they will have the cost-benefit effect desired.

Mr. FLOOD. They don't want to abandon them, do they?

Secretary MATHEWS. Delay or withdrawal of the regulations. My position on that, Mr. Chairman, is that certainly we ought to, in proceeding with this, make certain that we monitor the effect. For that reason I have set up an advisory committee that will constantly look at the effects.

But I would submit two things: first, these regulations were 2 years in developing. Again, a very thorough study was made of what they would or would not do. The issue was vigorously examined and reviewed. Short of some conclusive evidence to the contrary, I believe it proper to move ahead with that decision.

However, in deference to those concerns, we have added to our procedures this advisory committee which would monitor the effect of the regulation. As for the particular difficulty of whether April 26——

Mr. FLOOD. They tell me it is not in their budget. You are right in the middle. You want to implement these regulations right smack in the middle of their fiscal year.

Secretary MATHEWS. We have not taken into the decision——

Mr. FLOOD. Suppose we did that to you. I know Miller would be up here kicking the door in.

Secretary Mathews. Well, we are prepared to work with any State as to practical problems as to dates or timing or that kind of thing. But our decision is that we should go ahead with the MAC regulations.

Mr. Flood. What about the State medical assistance program administrators? That is obviously the group of administrators handling the medical assistance program in the States. They are pros; they must be.

Secretary Mathews. Their principal objection was whether to go ahead with the regulations. We differ on that.

Mr. Flood. I can't think they mean that. I think they mean delay for this fiscal year. How about December 31?

Secretary Mathews. The principal request for delay has been because the argument is that we can't go ahead until we know what would happen. I would submit that we will never find out what would happen until we go ahead. I think we have an obligation to constantly monitor it. We are delighted to work with any State on a technical problem as to dates or something like that.

Mr. Flood. I understand this maximum allowable cost program is based upon the premise that all of these drug products are interchangeable.

Secretary Mathews. No, sir. It is premised on the assumption that some drugs are. If a physician does not feel that there is bioequivalency, he has the opportunity to prescribe another drug, and we will reimburse.

Mr. Flood. You are putting the cart before the horse. That seems to be the problem. If you have those standards and you are putting those standards in place, if those standards are in place before you implement the MAC regulations you certainly have the cart before the horse, don't you?

Secretary Mathews. All the standards are, a list of drugs in their generic forms and the statement that we will pay for the drug that is of lowest cost.

Mr. Flood. You are going to meet with these people on the very thing we are talking about?

Secretary Mathews. I am certainly open to meeting with them on any technical problems they have on dates.

Mr. Flood. Will you get ahold of them and find out?

Secretary Mathews. I believe we have been in touch.

Mr. Flood. Pennsylvania, New Jersey, West Virginia, New Hampshire, Maine. That is quite a collection.

Secretary Mathews. Yes; we will meet with them again as to problems they have in the context of this decision.

Mr. Flood. We are concerned about the costs here. We are talking about $17 or $20 million. That is not high for the Appropriations Committee.

Secretary Mathews. In trying to be sensitive to that concern we have put in the advisory committee to look at costs and the actual impact so we can get the pulse rate of the patient while we are proceeding.

Mr. Flood. When you have this meeting with those people from those States will you advise the committee staff of the results of it, who was there, when it took place, what happened, et cetera, so they will know?

Secretary MATHEWS. Most assuredly.

Mr. FLOOD. One more question.

REGULATIONS

Why in the world don't you clarify some of those fantastic HEW regulations? I work on the Defense Department appropriations and I thought they were bad but you can't put a glove on HEW. I can translate three languages but I can't put a glove on you people.

Secretary MATHEWS. We are very sensitive to that.

BLOCK GRANTS IN GENERAL

Mr. MICHEL. Going back to the block grant approach, it seems that once we decide on the block grant, from now until the country expires we are going to have the same block grant. I don't subscribe to that, do you?

Secretary MATHEWS. No. In two instances we are incorporating previous block grants into large blocks so I think we are very properly modifying the nature, extent, and scope of that block grant as the capacity of States develops and as we are able to transfer responsibility.

Mr. MICHEL. Isn't it true that if we draw the guidelines so tightly on anything called a given block grant, you are going to have nine grants in one specific area of education, or health or what not and you have not gotten away very much from your categorical criticism that we are trying to get at?

Secretary MATHEWS. That is absolutely correct.

Mr. MICHEL. So when you fold in two or three or four small specific block grants into one large one, it means that you simply are giving more flexibility to that local and State community to make the decision within a broader framework of resource.

Secretary MATHEWS. That is correct.

FOREIGN TRAINED DOCTORS

Mr. MICHEL. On the foreign doctor business, isn't it true in the last several years that one-third of the new doctors licensed in this country are either foreign-born or foreign-trained?

Secretary MATHEWS. Of the new physicians, that is true, roughly.

Mr. MICHEL. So if that kind of condition prevailed over a sustained period of years, it is quite conceivable isn't is, that at year "X" some time in the future you are going to have a total of 25 percent of your doctors foreign-born or educated or trained, if it goes on for an extended period of time.

Secretary MATHEWS. That is conceivable. Our latest projection shows that by 1980 the supply of Foreign Medical Graduates will increase slightly to 25 percent.

Mr. MICHEL. That is really what has happened in this country. A question was raised in my mind. How many foreign students do we actually have currently attending medical and dental schools in our country?

Secretary **Mathews**. Not half so many as we have Americans in foreign countries attending school. I don't have the specifics.

Mr. **Michel**. Is it equal?

Secretary **Mathews**. No. I suspect we have more Americans in foreign schools than we have foreigners in American schools.

Mr. **Michel**. Absolutely. Then fill out the record so that we might have the precise figures there. Of course, on one hand that is supposed to be out of a sense of compassion and goodwill and all these other things that we are trying to do for our less fortunate neighbors and friends abroad.

Can you take the extreme argument and say in view of these times we have no business being that compassionate, to heck with it, we are going to limit it to just American students, but we don't do that. But that is in another area. You ought not to be criticized in that area.

Mr. **Patten**. Our American students who are forced to go to Mexico get no aid at all. Some of the medical students I meet are either in Hong Kong or Rome. My people can't get into medical colleges. There is no room for them. But we don't help these students paying $5,700 down there in Mexico. We don't give them a nickel, right?

Secretary **Mathews**. Unless they transfer back. Most medical schools have programs to allow for transferring back.

Mr. **Patten**. Did you ever try to work a transfer?

Secretary **Mathews**. Yes.

Mr. **Patten**. Maybe you can do it but I can't. I am working on three of them now and I am going to score zero.

Secretary **Mathews**. I would not tell you that it was not as difficult as you know it is.

UNCONTROLLABILITY OF FEDERAL BUDGET

Mr. **Michel**. Mr. Secretary, in your statement you talk about 97 percent of your budget being uncontrollable. You go on to state that this doesn't mean that nothing can be done about spending levels for these programs. I have criticized our own members of our committee in this regard, and at one time was subject to the same criticism myself because I talked about, and still frequently catch myself talking about, uncontrollables, when as a matter of fact if we as the Congress saw fit to control them, they would not be uncontrollables because we still have the power in the Congress to alter them. They are not beyond our power to control if we set our mind to do it.

Now we have actually given you considerable power and opportunity through the regulatory process. That can work both ways. If we give you too much latitude and you don't do what the Congress thinks you ought to do, we get off the hook by passing the buck to you.

But nevertheless there are some areas, maybe welfare is a good example, where you have effective power to control expenditures. Prior to your arrival a quality control program was established as a means of forcing the States to tighten up on their welfare programs. It seems to me the primary incentive in this regard has been the threat of a reduction in Federal funds. But I understand the

Department has chosen to delay application of a penalty against the States for failing to comply.

Why is this? Is it too tough an incentive?

USE OF PENALTIES AS PROGRAM SANCTIONS

Secretary MATHEWS. We, as a matter of fact, have, in my tenure, enforced nine penalties and taken money away from States under appropriate statutes. There is one statute that has to do with utilization control, utilization regulations. In that instance the Secretary is, by law, entitled to a satisfactory showing that some States are in fact different from other States in their behavior and performance.

I have made an exhaustive study of this. In fact, the Department has spent some $2 million to look into this matter. I cannot make a legal distinction between the performance in one State and the performance in another State.

Mr. FLOOD. Would you yield? Mr. Secretary, how long have you been onboard now?

Secretary MATHEWS. Six months.

As you know, if you are unable to make a legal definitive distinction in the performance of one, then you have the choice of taking the money away from every State, which I assume is not what Congress intended. I can go back and take $6 billion away but that is not what you want.

So I believe our attention to this effort has resulted in marked improvement in utilization in hospitals. I believe further that we have a way of improving utilization through the PSRO organizations which is much more effective and will result in a savings this year alone of $150 million in reduced costs by better utilization of hospitals.

So we have never failed to follow the mandates of the law with respect to utilization of penalties. We have enforced the law with regard to other penalties. We have other methods for dealing with the utilization control problem.

Mr. MICHEL. Have you any idea that without imposing a threat of penalty the States by themselves voluntarily will clean up some of their messes in this regard?

Secretary MATHEWS. I think there is considerable question as to the effectiveness of the general posture of the Federal Government which is to go in and threaten massive retaliation that is not targeted against the people whose behavior you want to change.

What the Federal Government does is to go in and threaten to deprive the people you intend to help. I really think that we all ought to think twice about the effectiveness of that method. It seems to me that a much better approach is, if we are going to work with States, than I think we have to accord them the same measure of faith that we accord ourselves, that is that we have to assume that they are honorable and competent people, no more or no less so then we are at the Federal level and that we have to find a more effective partnership with them.

I don't believe that partnership can be based solely on threats or throwing our weight around. I think there is a better way to do our business.

WELFARE REFORM

Mr. MICHEL. You make reference to legislation which would "standardize requirements to aid to families with dependent children to make them more equitable and less costly nationwide."

What kind of legislation are you referring to and how would it save Federal dollars?

Secretary MATHEWS. Well, as you well know from your own work with welfare reform, we have a great many overlapping standards and different standards and that complication results both in errors and in misspent money and in great administrative expense.

The classic case is the food stamp program where the costs of that program are nearly 20 percent of the total expenditures. In this particular case we would propose to use similar standards in medicaid and AFDC because you are dealing with much the same populations there, with dependent populations. We think at any point where we can take programs that are similar for similar populations and use essentially the same approach, that we will cut down the duplication.

We can give you further details on the particulars.

Mr MICHEL. I don't want to take an extended period of time. I can fully appreciate it gets to be a little technical, particularly when we are talking about different sections of the country.

My first reaction to standardizing, well and good, it is a good principle and very idealistic but that has been one of our big problems, the fact that New York City is so far above what we can live without in Peoria. So we have these tremendous variables and disparities.

Secretary MATHEWS. The proposals we make are largely technical and have to do with calculations of income and tnat kind of thing and do not deal with that. We will be glad to give you a detailed report on our AFDC costs.

Mr. MICHEL. As you know, I am a co-sponsor along with many other Members of the House and Senate in welfare reform legislation which the staff has estimated, your staff, would save between $1.7 billion to $2.2 billion annually. It has come 25 separate provisions for reform of the AFDC program.

Have you had an opportunity yet personally to look at enough of those specifics to give us an idea whether they are viable, whether you feel you can move ahead or if not, why you are reluctant to do so? Do you feel inhibited by the fact that the Congress itself has not really mandated that you do so like it has several times in committee reports with the Department of Agriculture and the Secretary there in his area and programs?

Secretary MATHEWS. I made it a point to make myself familiar with this program. I am aware that we owe you a comment on your proposal. That comment was well coming along when the President made his budget proposal and we are now having to redo some sections of that to make sure it is in conformity with what the President's position is.

You are entitled to that and it is my position to see that you get it.

Mr. MICHEL. Just for the sake of the record so that it flows smoothly, one of the provisions would be to reverse the method by which we compute the so-called $30 and one-third first and then work-related expenses. The way we do it now is to deduct the $30 and one-third first and then work-related expenses which has the effect of deducting one-third of the work-related expenses twice.

Now my question to you—and feel free if it is more comfortable to answer simply for the record—is whether this does make any sense to you? I happen to know or feel it was one of those midnight regulation changes by outgoing Secretary Wilbur Cohen a number of years ago. I want to know why we have not sought to change it back.

I guess in the interest of time I will be happy to let you respond to it in the record.

Secretary Mathews. I will be pleased to.

[The information follows:]

As a part of the fiscal year 1976 budget, the President requested a legislative amendment to the income disregard provision which would have corrected the anomaly in present law. Section 402(a)(8) requires that "the first $30 of the total * * * earned income * * * plus one-third of the remainder" shall be disregarded in addition to "any expenses reasonably attributable to the earning of any such income." This language has two serious defects: (1) it allows each caseworker to define work expenses as he or she sees fit, and (2) it allows such large disregards that families with substantial incomes (sometimes in excess of the poverty index) remain eligible for benefits. The President's fiscal year 1976 proposal, which has been resubmitted as part of the fiscal year 1977 budget, would modify the income disregard by increasing the initial disregard from $30 to $60 and eliminating the work-related expenses deduction, except for child care expenses. This change would standardize the application of the disregard in all cases and reduce the number of families remaining on the rolls long after their income has risen substantially.

Mr. Michel. Then I have several others here that get a little more technical in nature that we would like to have responses for the record. I will submit them when I finish.

ENFORCEMENT OF ABSENT PARENT SUPPORT

With regard to the new parent locator service which is designed to help find absent fathers. I remember in my early freshman days having a so-called runaway Papa's bill. Most of the people feel the use of social security numbers is the best way of going ahead with this. But I understand that you have ordered the general counsel that such numbers not be used. Is that true?

Secretary Mathews. We have tried to take a consistent position in light of the Privacy Act so that what we do is uniform throughout the Government.

I had a general counsel's opinion as you described that we did not as a practice give out these numbers to anybody for any purpose. I have subsequently been advised on further investigation that that is not correct. I have that matter under advisement at the present time.

What we will do is try to make a determination as to what are the requirements necessary for this program to be effective. And what are the requirements under the Privacy Act? If there is any conflict, we will advise the Congress that one law seems to prohibit the other or we might determine that they do not conflict. Then you can say whether the practice conflicts with the law.

Mr. Michel. I have heard some estimates that the loss in Federal and State funds due to deserting fathers comes to $7 or $8 billion. It is rather hard to believe any reason offered would be sufficient to stand in the way of our making the most effective effort possible to overcome such misused tax dollars.

Secretary **Mathews.** I agree with you as to the import.

Mr. **Michel.** As much as I would like to respect the right of an individual's personal privacy, et cetera, I am very sensitive on that subject. I will tell you, in this area I have some reservation about the other reservation.

I would think that maybe you ought to really look at this one closely because it is getting to be a terrible problem.

Secretary **Mathews.** I might say that we have every intention of doing everything we can to implement that law which has to do with the location of absent fathers. On the other hand, as you would clearly recognize, we cannot be in violation of other laws. If we find that there is a legal problem, we will call it to your attention so that you can advise us.

Mr. **Michel.** Thank you.

Now you have some proposals to control medicare costs.

Secretary **Mathews.** We do indeed, sir.

MEDICAID COST CONTROL

Mr. **Michel.** But I don't see anything with respect to medicaid costs which seem to be rising the most rapidly. I guess my question has to be, what are you doing about medicaid costs?

Secretary **Mathews.** That is in the health block grant. We are making some recommendations in the transmittal to the States as to ways they can be more effective in that program.

As you already know, the medicaid program is a State-administered program at the present time. I am quite concerned as I am sure you are about recent reports about abuses of that program and the need for greater care in its management.

QUALITY CONTROL OF INCOME ASSISTANCE PROGRAMS

Mr. **Michel.** In that quality control program you mentioned an error-rate statistic. I think it was 24 percent in your testimony and you then said 22 percent. Is it 24 percent?

Secretary **Mathews.** That is the SSI error rate in 1975 that we project to drop to 15 percent by the end of fiscal year 1977. AFDC is roughly the same.

Mr. **Young.** Before the QC program in AFDC that was running 41 percent. As a result of QC and other tightening up, it has dropped to 31 percent whereas SSI is 24 percent.

Mr. **Flood.** By QC you mean quality control.

Mr. **Michel.** 20 percent of $9 billion is $1.8 billion in medicaid overpayments.

Secretary **Mathews.** I think we ought to be aware that when we talk about discrepancy in the SSI program, there are legitimate concerns about actual overpayments. But that in 20 percent you are also getting figures which come about in this way: If you are the caseworker and I am the client and you take the laws that determine my eligibility and you ask me my status I may, on the day I come in, fit perfectly with those laws. Two weeks later I may get additional income, I may lose income, I may move in with my family and my status may change.

When an auditor comes along and checks for my entitlement, there may appear a discrepancy between his findings and the findings of the caseworker. Those are reported in the category of error.

I would submit to you that rather than error, they are simply reports of discrepancy and reflect diligence on the part of the Department rather than incompetence. So what we report generally—and we use the term as error—encompasses both figures.

So we cannot say with any accuracy, therefore, that this means we are wasting and inappropriately spending 20 percent of our money.

Mr. MICHEL. Now the word I get is no effort is made to prosecute the payment of illegal benefits discovered in the sample survey despite the part of the law that says action should be taken; is that true?

Secretary MATHEWS. We are proceeding to try to recover overpayments and inappropriate payments. But in a recent court order the court has required that we give a hearing in each of those cases. I believe the number of those cases is 3.1 million.

The requirement to give hearings in 3.1 million cases will substantially affect our ability to recover those moneys.

Mr. MICHEL. In any case, it is good to have it spread out on the record. I know we have a problem. Obviously it is a very serious one.

Secretary MATHEWS. Yes.

Mr. MICHEL. What kind of a program do you have to root out fraud and abuse in the medicaid program such as those kickbacks to doctors that I watched on the CBS "60 Minutes" program Sunday? That was a devastating kind of thing.

I came through Chicago on my way coming out here and picked up the papers and that is all they are talking about, the story up there about what is going on in the city of Chicago with respect to the laboratories, kickbacks, and all the rest. I don't know what the listenership or viewer rate is of that program but I can just imagine within a couple of days we are going to get flooded again with a big batch of correspondence, "what in the devil are you doing, Congressman, about cleaning this thing up? You have just taken pride in being on that committee, et cetera, et cetera, the heat is on."

OFFICE OF INVESTIGATIONS

Secretary MATHEWS. I can describe to you what we are doing. I would want to point out again that the very first thing I did when I took this office was to create an Office of Investigations, for the first time in the Department to concentrate on criminal investigations.

Mr. MICHEL. We certainly need that.

Secretary MATHEWS. We have that Office with the temporary Director. We are in the process of getting a permanent Director. We have additional slots. So we now have for the first time a major criminal investigative unit.

Mr. MICHEL. Are they reporting directly to you now?

Secretary MATHEWS. To the Under Secretary.

Mr. MICHEL. Well, not down through all the bureaucracy so everything will be covered up on the way up.

Secretary **Mathews**. We have pulled the investigative units out of the line units and consolidated them in the central unit so we get direct focus. We have arranged for coordination between the criminal investigators and the auditors. The auditors are the large force who discover these matters.

Second, we have some proposals up before Congress for remedies and improvements. Then, of course, in the AFDC program we have our regular management group. Mr. Young is quite familiar with this and probably could assist you by commenting on it.

Mr. **Young**. As a result of the reports to this subcommittee and likewise in the Senate, the two committees have asked us, the Secretary particularly, to report on all of these programs, medicaid, medicare, student loan programs, the campus-based programs, SSI and AFDC. We have done that.

The two reports that you don't yet have are on medicare and SSI. I would like to point out in the case of Illinois and Chicago, all of the matters that were reported outside of the kickbacks were previously reported by the HEW audit agency to the officials in Illinois. The Moss committee report pays due respect to what the audits had done.

The auditors are not normally in a position to do what I call face-to-face criminal investigations. That is what you have to do when you are into the rebate or kickback business. That is what the criminal investigators will do.

We now had only 10 in the past and with the great assistance of this committee and the Senate committee it will go up to 70. Without violating the rules of the budget game, it may or may not be adequate when we get through an analysis of caseload. There is a large caseload built up over time. We may have to come back to the Congress and come to the President for additional investigators.

Mr. **Michel**. You are going to get a sympathetic ear here. I know the severity of the problem. Far be it for me to force new people on a department when I normally take another stance but in this area where there is so glaring a deficiency, we have to have better monitoring and surveillance of these mammoth programs to make sure we don't have these horrible instances.

Mr. **Young**. The Secretary, the Under Secretary, who is not here, and I would like to get the reactions of the committee to the reports. We have summarized the reports and written a report on the characteristics of the programs that create some of the basic problems. The complexity of programs like determining income and cooking arrangements can be an important factor, which SSI has to get into. If you change cooking arrangements, then you have to make a new determination. When you think about claim takers in what used to be the social security system making all of those detailed decisions, frankly, about how a person lives and what cooking arrangements there are, there is going to be a certain level of errors. We will never get it to zero.

Yet there is an ethic, a proper ethic in this country that says that every tax dollar should be accounted for. We have great difficulty. The difficulties, as you study them as we did in the SSI study group, indicate one thing: these programs need major simplification, and at the same time greater equity. Another matter the Congress is interested in. However, simplification normally costs you more money.

Mr. Flood. Thank you very much. We will recess until 2 p.m.

AFTERNOON SESSION

Mr. Flood. The subcommittee will be in order.

Mr. Natcher?

DEVELOPMENT OF FISCAL YEAR 1977 BUDGET

Mr. Natcher. Mr. Chairman, thank you.

Mr. Secretary, I know that you have only been in office now for only a period of some 6 months, but I am just wondering if you have been there long enough to have any idea about how many individual programs HEW is now administering.

Secretary Mathews. Somewhere between 275 and 300.

Mr. Natcher. The HEW budget reflects hundreds and perhaps thousands of decisions about funding for many different programs.

Could you describe to us, briefly, the decisionmaking process within the executive branch which resulted in the budget which is now before us today, keeping in mind, Mr. Secretary, the part the President has played in this undertaking as well as your activity, and those of the staff of OMB?

Secretary Mathews. Yes; I can.

Mr. Natcher. Go right ahead, Mr. Secretary.

Secretary Mathews. The budget process, of course, began for this budget you have before you, began before I arrived. The Department developed in the summer positions on the various issues, and financial proposals for various types of programs.

Then late in the fall the Office of Management and Budget developed its guidance as to what it felt like the overall budget would be, and what each particular department might have to work with.

That was followed by a series of meetings between members of our staff and the White House staff which culminated in a meeting with the President in which I, the Under Secretary and the principal Department officials laid before the President the point of view that we felt like we were obliged to call his attention to.

The President considered those recommendations along with others which would include a recommendation of OMB or the Domestic Council or any of his other advisers who advise him on these matters, and then he made his decision and he communicated those decisions to us and we completed the details and you have the results before you.

Mr. Natcher. Mr. Secretary, are you satisfied with the budget that you are presenting to this committee at this time?

Secretary Mathews. I am fully in support of this budget and prepared to defend it vigorously. It's certain that, if this is the point of your question, that in all cases professionals within our Department may not find themselves in the position of saying that this budget is exactly what they would have had.

But, on the other hand, they did not have to make the decisions, which they would fully admit to, of the scope and magnitude that the President did.

HEW BUDGET VERSUS DEFENSE BUDGET

Mr. NATCHER. Your predecessor, Mr. Secretary, on two occasions in presenting the budget for the Department of Health, Education and Welfare, compared this budget with the budget for the Department of Defense.

Mr. Miller, who sits there to your left, can tell you that on one occasion I took his statement 1 year and read it back to him the next year, which was almost word for word the same statement, defending reductions in the budget for Health, Education, and Welfare, based on the fact that we had to have all of this money in the budget for Defense.

Almost word for word he himself, as Mr. Miller will tell you, admitted that the statement was almost copied the next year which I thought was a right bad mistake, attempting to justify the budget for Health, Education, and Welfare and the reductions on the fact that we had to have tremendous increases in the Department of Defense.

What is your feeling about this, Mr. Secretary, as far as HEW is concerned? Do you believe that the amounts in this budget, the reductions in this budget have any relationship to the Department of Defense budget or any other budget for any other department in the Government?

Secretary MATHEWS. I am not familiar with the Department of Defense budget, nor have I ever discussed our budget in relationship to anybody's budget.

I would simply point out to you that our budget is increasing both in size and as to a total percentage, as a percentage of the total Federal budget, and I believe that our percentage of increase for our Department as a part of the Federal budget is larger than the Defense increase.

Mr. YOUNG. That is correct. If you take the total budget for HEW, it's about a 10-percent increase, if you assume the runout in 1976 will be $128 billion. That adds $12 billion. Whereas the Department of Defense budget increases by about 9 percent or $8 billion on a base of $93 billion.

Mr. NATCHER. With the exception of the amounts pointed out by my chairman, some $40 or $41 billion, the rest of the bill before the committee at this time, Mr. Secretary, consists of trust fund money. Isn't that correct?

Mr. YOUNG. That is correct.

Mr. NATCHER. Almost in its entirety.

Secretary MATHEWS. With the exception of $44.2 billion.

Mr. NATCHER. I understand.

Secretary MATHEWS. And that $44.2 billion is $2.1 billion above the 1976 appropriation, so there is an increase in appropriations as well as the total.

Mr. NATCHER. Do you agree that if after careful consideration of the budget estimate this committee should reach conclusions which differ from the budget requests, that we both have the right and the duty to recommend changes, either up or down to the House of Representatives?

Secretary MATHEWS. It's my understanding that the function of Congress is to dispose of the budget recommendations the President makes in such ways as it sees fit.

Mr. Natcher. As the chairman has pointed out, you know, Mr. Secretary, your 1977 budget proposes cuts of over $2 billion in health and education programs. I have my doubts that Congress will accept these reductions. I don't think that the chairman of our committee, Mr. Flood, has any chance whatsoever to take this bill to the floor of the House with those reductions and have the House of Representatives sustain it.

I say that to you on the record, Mr. Secretary.

Secretary Mathews. Yes.

Mr. Natcher. If Congress adds $2, $2½ billion to the HEW budget, for fiscal year 1977, and makes a cut of comparable size elsewhere in the President's budget request, the overall request, Mr. Secretary, do you think the President should veto the HEW appropriation bill again this year?

Secretary Mathews. I think it's impossible to anticipate what the President might do under a set of circumstances that are not descriptive at this point.

Mr. Natcher. Suppose we put the money back in, the reduction that the chairman has pointed out to you, and that was discussed this morning, would you recommend a veto under those circumstances, Mr. Secretary, if this money was put back into the bill?

Secretary Mathews. I am only prepared at this time to advocate and defend and say that the administration would support the legislation or proposals that are here before you.

I have no authority to indicate that the administration would support anything other than this.

Mr. Natcher. It is my recollection, Mr. Secretary, that this is the 3d or 4th consecutive year that we have had a veto of HEW appropriations.

Mr. Patten. We had two in 1973 by President Nixon.

Mr. Flood. We have had five of them altogether. Two were overridden.

Mr. Natcher. We have had five, I believe, Mr. Secretary.

Secretary Mathews. That is correct.

Mr. Natcher. Since I have been a member of this subcommittee.

Now, do you believe that the people of the United States who are the real beneficiaries of the HEW program, and this includes nearly all of our people, would be better served if we could work a little bit closer on this bill, Mr. Secretary, instead of having a veto every year, and knowing it's going to be vetoed, and also knowing that the Congress will not accept the reductions that you and your predecessors have made? Don't you believe we could work together a little better on this bill?

Secretary Mathews. I am sure the President would be anxious to have every accommodation he could with the Congress.

On the other hand, I should say to you that he feels very strongly about this budget. He participated personally, as I have described earlier, in the formulation of the budget, and he believes it reflects a mandate that he has from the people that pertains to the relationship between the people and the Federal Government that he has tried to express in the details of this budget and he is sincere and earnest in his petition to you to consider his budget as he has proposed it.

Mr. Natcher. Do you have any suggestions to make to the committee at this time as to how we can avoid the annual confrontation between the executive branch and the Congress over this particular bill?

Secretary MATHEWS. There was discussion in another committee about some agreements we might have or might try to reach about the budgeting process, and the proper integration of the Congress new budgeting procedures with the administrative process. These are the only particular conversations that I have had, other than to indicate to you what I am sure is the President's basic desire to work with Congress wherever he can.

HEW STAFF

Mr. NATCHER. Mr. Secretary, how many employees do you have in the Department?

Secretary MATHEWS. Roughly 140,000, sir.

Mr. NATCHER. Do you have sufficient resources that you need to effectively administer this Department?

Secretary MATHEWS. I believe that the programs can be administered with the personnel that we are requesting in the 1977 budget.

In some cases we have asked for increases, in other cases, where we propose to eliminate programs, well, quite naturally, we would be then able to reduce those personnel.

Mr. NATCHER. Do you intend to fill all of the positions which Congress has given you for the fiscal year 1976?

Secretary MATHEWS. That is always my intent, yes.

PROBLEMS IN THE ADMINISTRATION OF HEW PROGRAMS

Mr. NATCHER. From time to time we hear criticisms about the bureaucracy. It is often fashionable to blame the bureaucrats when Government programs don't seem to be working, as you well know, and Mr. Secretary, you knew that before you arrived in Washington.

Secretary MATHEWS. Indeed I did, sir.

Mr. NATCHER. Overpayments, Supplemental Security Income, medicare abuses, delays in benefit payments are among the problems we hear so much about on this committee.

What have you found out at HEW, that the problem is due to poor management or what is the problem. What is the difficulty, Mr. Secretary?

Secretary MATHEWS. The basic problem is that, as you alluded earlier, the bureaucracy is no more than our own creation. It didn't come here from Mars. We created it ourselves as a people in the legitimate processes of government over a period of time.

We incorporated though, into that machinery, all of our conflicting ambitions as American people and the reason that things don't turn out as we want often is usually the result of the fact that we are of a divided mind as to how they ought to turn out, and until we happen to hit that unusual day in this country when every citizen of this country is of a like mind, I think that we will have that fundamental problem with us, because I think it is endemic of human nature.

That does not mean that I don't believe that there are things that can be done to improve the bureaucracy and make it more responsive to the people of this country.

As a matter of fact, that is a task that I have set myself to with such diligence, and intelligence as I could command.

INTERNAL MANPOWER MANAGEMENT

Mr. NATCHER. This committee has been pressing the Department of Health, Education, and Welfare for several years to fully implement a manpower management program. What is the status of this program at the present time? Can you give us any information along this line?

Secretary MATHEWS. I believe that Mr. Young is probably familiar with that and the details.

Mr. NATCHER. Go ahead, Mr. Young.

Mr. YOUNG. I would say we are not happy with our manpower utilization program.

We are in the process of seeing if we can't find a better way to integrate the staff that is working on manpower utilization with the budget staff.

Members of the committee I know are familiar with the budget process as an action forcing process and, therefore, what we do in manpower has to be better tied to do that.

Mr. Miller and I have held conversations this week with Dr. Ottina to that end. That's one point.

Point two is in the last analysis, good manpower utilization has got to rest with the program directors. It cannot be run out of the front office. That can end in disaster, in my book, so we have got to insist and Secretary Weinberger did this, and the present Secretary has, that people like Commissioner Cardwell, Dr. Cooper, and so forth, see that the manpower that is available is well utilized.

It is not an easy task because you take the utilization of manpower in a situation like the National Institutes of Health versus Social Security, which are pretty different product lines, so you have to adapt the techniques to the different conditions.

I think in my 2 years in the Department some admirable things have been done, particularly in the better utilization of manpower in SSA. It's not all perfect.

Also in some of the health services, taking a look at the Public Health Service hospitals, some good work has been done there.

Are we satisfied? No; indeed.

PROPOSED IMPACTED AREA AID CUTS

Mr. NATCHER. Mr. Secretary, in your statement to the committee you pointed out that as far as Impacted Aid is concerned, the title B category was deleted from this budget.

Secretary MATHEWS. Yes.

Mr. NATCHER. Mr. Secretary, don't you know as well as I do that my chairman couldn't take this bill to the floor and leave title B out? He would have no chance whatsoever of passing this bill.

Secretary MATHEWS. I understand that there has been a long problem with the passage of this recommendation. On the other hand, I would call to your attention again that this has been a matter that has been decided not only by the executive branch of Government, but also by other parties who have addressed themselves to the question of good government, and have identified this particular program as one that is highly questionable as a governmental expenditure.

Mr. NATCHER. Mr. Secretary, I have a good friend that is your good friend and he recommends you very highly as far as I am concerned. His name is Frank Rose. Frank Rose, as you know, was president of a college in the Commonwealth of Kentucky, and he was your predecessor I believe at the University of Alabama.

You probably know something about Kentucky. Hardin County is a county where Fort Knox is located. You have probably been there, Mr. Secretary.

Don't you know that as far as title B is concerned in Hardin County, Meade County, Breckinridge County, La Rue County, Barren County, and the other counties around that military installation, why the school systems would have to cut back or close. They would have to take all of those students, with no assistance from the Federal Government?

What is going to take the place of this omission in the budget?

Secretary MATHEWS. I believe that we are only proposing to eliminate certain portions of Impact Aid and we do not propose——

Mr. NATCHER. Well, do you propose to delete all of title B?

Secretary MATHEWS. Right.

Mr. NATCHER. But not A?

Secretary MATHEWS. But not A.

Mr. NATCHER. Oh, certainly. You know the burden that is carried by the local districts and title A is not the major factor. They are carried under title B, you will agree with that?

Secretary MATHEWS. I would not minimize nor take exception to the difficulty in the proposal that we have made to you. I know it is a difficult thing to ask.

Mr. NATCHER. Mr. Secretary, the President of the United States is a friend of mine and he is a friend of every Member of this committee.

He served with us for about 14 years. I think he was elected and came on this committee the same time I was elected a member. I have completed 21 years on this committee. And he knows as well as I do today that a lot of these reductions in HEW are automatically going to be restored.

He knew that when he approved this budget and, Mr. Secretary, after you have served 2 or 3 years my chairman will tell you every year when you come and, when you cut this budget in education, certain sections of health and you go into Impacted Aid especially, we have got problems.

Thank you, Mr. Secretary.

Secretary MATHEWS. Thank you, sir.

Mr. FLOOD. Mr. Michel?

FRAUD AND ABUSE IN HEW

Mr. MICHEL. Thank you, Mr. Chairman. If I might follow on the line of questioning this morning, Mr. Secretary.

You are, of course, familiar with the recent report of the House Government Operations Committee which stated among other things, the following:

> HEW officials were unable to provide the subcommittee with meaningful estimates of the extent of losses through fraud and abuse in programs of the Department, advising that no attempt had been made to evaluate the overall extent of the problem.

There is no central source of data on fraud and abuse, so statistical information is available but much of it is incomplete and considered unreliable.

I guess our question has to be, have you developed any such estimates since those hearings were held, or if not——

Secretary MATHEWS. Indeed we have taken a number of actions since that report was made to you.

I have described my own in the creation of the Office of Criminal Investigation, and Mr. Young has referred to the reports that he has sent to you, and I believe those speak to that point.

Mr. YOUNG. That is correct. Those reports, to the best of our knowledge, cover estimated impact of misuse and fraud.

I think the numbers are reasonably good where you have a quality control situation like in the aid to families of dependent children, you can cost-out those error rates.

And I would like to correct the record if I remember the numbers incorrectly. I think if those error rates in the aid to families of dependent children stay around the 31 percent, you have roughly a loss of a half billion dollars a year in Federal and State funds.

We have estimates on most of these problems, like medicare and so forth. The one that we are uncomfortable with, to be very frank about it, is medicaid.

Mr. MICHEL. Medicaid?

Mr. YOUNG. Medicaid, the numbers on medicaid are not as good as they should be. We know we have problems in medicaid. The audit reports show that. The excellent report of the Senate committee the other day which perturbed all of us, points out problems in that field. But as ways to measure what the risks and the dangers are, the numbers are not satisfactory.

But in all of these other areas, and we do have things underway to get better numbers in terms of the threat in the medicaid programs, several steps are underway to do that. You may recall, the committee authorized 119 positions for the medicaid program in the 1976 budget, which will be used to staff a new abuse and fraud unit which will begin working with the States to get on top of this problem.

Also HEW last July began to put in place a quality control system in the medicaid program similar to the program that has been used in the aid to families of dependent children and in the SSI program.

OFFICE OF INVESTIGATIONS

Mr. MICHEL. Now, this morning or earlier, both you and the Secretary made reference to the newly expanded Office of Investigation, and do I understand this Office is going to represent the heart of your efforts to get at fraud and abuse? Will it actually be searching out illegal activities as well as pursuing the investigation once such activities are discovered?

Secretary MATHEWS. Indeed, it is the heart of our effort to get at the question of criminal fraud and abuse, and we have every reason to anticipate that it will be vigorous.

I think to understand fully the way it would function, we need to also make clear that it would function in concert with our very substantial body of auditors that will give it added force.

So to understand the full dimensions——

Mr. Michel. Will the auditors be under the same direction as the investigators or are you going to have these two separate?

Secretary Mathews. No, they will not, but there are mechanisms set up to unite those. The work of the auditor is obviously different from the work of the criminal investigators but often the work an auditor does develop the material for criminal investigators.

Mr. Michel. But if there is any work——

Secretary Mathews. Right, we have worked out mechanisms to make certain that auditors reports get fed into the criminal investigative unit in a more efficient way.

Mr. Young. Yes, and in the case of the auditors discovering any allegation of fraud, they are to report that to the new Office of Investigations within 24 hours. That is one part of the equation.

The next part of the equation is, often when you get in a complicated fraud case you do need accounting people to run down some of your leads. Once the Office of Investigation takes over an allegation of fraud, then they have the opportunity to call directly on the audit staff for assistance.

If there is any conflict in terms of the workload of the audit staff, that conflict is settled under our new regulations by the Under Secretary. So I think these should make for a rather effective working relationship.

Mr. Michel. That Under Secretary is?

Secretary Mathews. Marjorie Lynch.

I might add for the record we have an auditing staff of nearly 1,000 people, so it's not an inconsiderable force of people working on it. I think the figure is more like 900.

Mr. Michel. Where do you stand currently on board with those additional people we authorized as investigators?

Secretary Mathews. Seventy. We are in the process, we have appointed immediately an acting director, and we are in the process of concluding the work to get the permanent director.

We had some, I think, 10 positions.

Mr. Michel. Where do you go for a director of investigations?

Secretary Mathews. We are looking really to the professional criminal investigative field for somebody with a background in criminal investigation, this is a professional position, career position, and we are looking for a career investigator for that position.

We are about to conclude that, I am told by the Under Secretary.

We, of course, had already filled positions that we had. Where we are exactly in filling the 70, Mr. Miller says roughly half of them are filled.

Mr. Young. But we picked up 18 of the positions from the Social Security Administration when we put those together, so we have about 30 vacancies to reach the level of about 70.

Mr. Michel. Are they going to be relayed out to the regional offices?

Mr. Young. Yes, sir.

Secretary Mathews. Oh yes, indeed they are. But we really have, by the amalgamation of two existing forces, two operational units that are on the line, and are prepared to go ahead, that is we are not in the position of having a totally new organization to contend with.

ORGANIZATION OF HEW

Mr. MICHEL. Now, let me get at a little bit of your organization.

Secretary MATHEWS. Yes, sir.

Mr. MICHEL. From reviewing your organization chart there are two assistant secretaries, 10 regional directors, 2 directors, a commissioner and an administrator and a host of others who report directly to you, and the Under Secretary. Who really has the line authority in the Secretary's office, and in these other management positions?

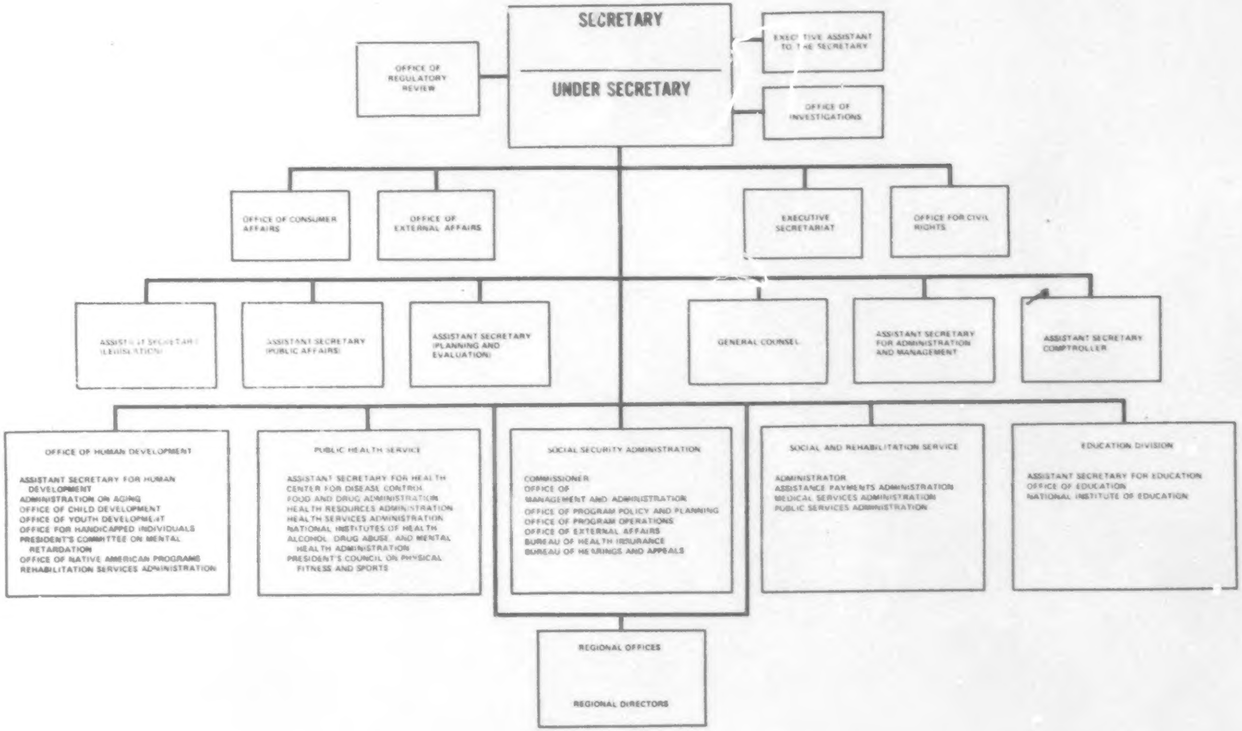
Secretary MATHEWS. I believe the chart you have is prior to my coming. I have made some changes because quite frankly there were too many people reporting to the Secretary.

Mr. MICHEL. I think we ought to have placed in the record at this point a new organizational chart or table of organization.

Secretary MATHEWS. Fine.

[The chart follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE


SECRETARY
UNDER SECRETARY
OFFICE OF REGULATORY REVIEW
EXECUTIVE ASSISTANT TO THE SECRETARY
OFFICE OF INVESTIGATIONS
OFFICE OF CONSUMER AFFAIRS
OFFICE OF EXTERNAL AFFAIRS
EXECUTIVE SECRETARIAT
OFFICE FOR CIVIL RIGHTS
ASSISTANT SECRETARY (LEGISLATION)
ASSISTANT SECRETARY (PUBLIC AFFAIRS)
ASSISTANT SECRETARY (PLANNING AND EVALUATION)
GENERAL COUNSEL
ASSISTANT SECRETARY FOR ADMINISTRATION AND MANAGEMENT
ASSISTANT SECRETARY COMPTROLLER
OFFICE OF HUMAN DEVELOPMENT
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT
ADMINISTRATION ON AGING
OFFICE OF CHILD DEVELOPMENT
OFFICE OF YOUTH DEVELOPMENT
OFFICE FOR HANDICAPPED INDIVIDUALS
PRESIDENT'S COMMITTEE ON MENTAL RETARDATION
OFFICE OF NATIVE AMERICAN PROGRAMS
REHABILITATION SERVICES ADMINISTRATION
PUBLIC HEALTH SERVICE
ASSISTANT SECRETARY FOR HEALTH
CENTER FOR DISEASE CONTROL
FOOD AND DRUG ADMINISTRATION
HEALTH RESOURCES ADMINISTRATION
HEALTH SERVICES ADMINISTRATION
NATIONAL INSTITUTES OF HEALTH
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS
SOCIAL SECURITY ADMINISTRATION
COMMISSIONER
OFFICE OF MANAGEMENT AND ADMINISTRATION
OFFICE OF PROGRAM POLICY AND PLANNING
OFFICE OF PROGRAM OPERATIONS
OFFICE OF EXTERNAL AFFAIRS
BUREAU OF HEALTH INSURANCE
BUREAU OF HEARINGS AND APPEALS
SOCIAL AND REHABILITATION SERVICE
ADMINISTRATOR
ASSISTANCE PAYMENTS ADMINISTRATION
MEDICAL SERVICES ADMINISTRATION
PUBLIC SERVICES ADMINISTRATION
EDUCATION DIVISION
ASSISTANT SECRETARY FOR EDUCATION
OFFICE OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
REGIONAL OFFICES
REGIONAL DIRECTORS

Mr. MICHEL. And what I am trying to really get at is, you know, what's the chain of command and the line of authority here, and how do you define the difference between line and staff personnel in the Department?

Secretary MATHEWS. Well, all of it, both line and staff assistant secretaries, report directly to me, not through the Under Secretary, with the exception of those that by law are excluded from reporting to the Secretary. In some cases you have sections of my Department by law that are not under my jurisdiction.

Mr. MICHEL. How many of those roughly, are there—many or just a few?

Secretary MATHEWS. There are major sections in the Office of Education and other places.

Mr. MICHEL. I think you ought to expand for the record and specifically, the authority under the statute.

Secretary MATHEWS. I will be delighted to do that.

[The information follows:]

ILLUSTRATIONS OF LIMITATIONS ON THE MANAGEMENT AUTHORITY OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Many provisions of statute limit the authority of the Secretary of Health, Education, and Welfare to manage his Department with the flexibility necessary to assure maximum effectiveness and efficiency. These limitations relate to such administrative concerns as reporting relationships, responsibilities of specific officials, delegations of authority, and creation or abolishment of organizational structure. The following examples have been chosen from among many to highlight the nature of the problem.

The Administration on Aging is required to report directly to the Secretary, and is mandated as a component of the Office of the Secretary. (Public Law 89-73.)

The Secretary may not delegate program authority for vocational rehabilitation to the regional directors, who are his personal representatives in the field. Only the Administrator of the Rehabilitation Services Administration may delegate program authority in the vocational rehabilitation programs, and only to subordinates who report to him. (Public Law 93-561.)

The Secretary cannot review the budget of the National Cancer Institute which is required by the Public Health Service Act to be submitted directly to the President (Public Health Service Act).

One statute, Public Law 93-380, contains many provisions which limit the Secretary's authority and flexibility. This recent act created 14 new bureaucratic components and established a rigid administrative structure in the Office of Education. Furthermore, the act restricts the role of the Department's regional offices in managing the education programs.

The Public Health Service Act specifies the organizational placement of certain research responsibilities, for example in: The National Institute for Child Health and Human Development (section 441); the National Institute on General Medical Sciences (section 444); and the National Eye Institute (section 453).

The Education Amendments of 1972 (Public Law 92-318) create a National Council on Educational Research to establish general policies for, and review the conduct of, the National Institute of Education (NIE). The act requires that this council's membership be appointed by the President, not the Secretary, and designates the length of the terms of the members without provision for removal. The act also requires that the council submit an annual report on the activities of the NIE and on education and educational research in general directly to the President and the Congress rather than through the Secretary.

In numerous provisions of law the Congress has assigned program responsibilities and authorities directly to the Commissioner of Education, thus restricting the Secretary's ability to manage the education programs.

Mr. MICHEL. The authority that defines those differences, because I know in some cases I frankly don't agree with them. I think they might even cause you problems.

Secretary MATHEWS. I will be very pleased to because that was one of the first investigations I made as to what I did and did not have jurisdiction over.

But to answer your earlier question, all of this, both line and staff principal officers report directly to me.

The Under Secretary handles special assignments such as the Office of Investigation and the Under Secretary concerns herself with certain of the administrative routines of the general Office of the Secretary.

The line components are those that we hold presently responsible for the operation of programs in the areas of health, education, welfare, and social security, and the staff divisions have a well developed system of working with them and making judgments on matters that are concentrated at the staff level.

For example, legal services are centralized under the General Counsel, and so it's appropriate for line recommendations to be reviewed there. And some of those recommendations have legislative implication, so they go to Mr. Kurzman for review before they would come to me.

But I put a great deal of stress, and have since my coming there, on the necessity to get responsibility and authority together, and clearly fixed in the line managers of the Department.

STATE WITHHOLDING FEDERAL FUNDS

Mr. MICHEL. We have a situation out in Illinois whereby the State is seeking to promote racial integration in the schools through busing, et cetera, and in talking about cutting off Federal education funds, going to communities, if such communities do not fully comply with the State desegregation regulations.

It would be my view that such an effort to use Federal funds as a method of forced compliance with the State regulation would not be permitted under Federal education law, not to mention the Byrd amendment on busing.

Have you got some thoughts on that?

Secretary MATHEWS. I am not prepared to comment at this time as to State law. But as you know very well, H.R. 69 very clearly indicates what the Department can and cannot do in respect to any kind of transportation and the Department operates consistent with that law.

Mr. MICHEL. Now, if you will please feel free then to expand in the record.

Secretary MATHEWS. Fine.

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

March 2, 1976

OFFICE OF THE
GENERAL COUNSEL

NOTE TO CHARLES MILLER, Deputy Assistant Secretary, Comptroller

Re: Congressman Michel's Inquiry to the Secretary Regarding Authority of a State to Withhold Federal Funds for Non-compliance with State laws (Darrel Grinstead's Note to Ted Sky dated 2/23/76)

The subject note from Darrel Grinstead (GCL) states that Congressman Michel has asked the Secretary if a State may withhold federal funds from federal grant recipients in order to force compliance with State laws. Congressman Michel has raised this question in connection with what are stated to be State of Illinois regulations designed to promote integration through busing and other means.

Our examination of the general question of State versus federal authority leads us to conclude that rights conferred under a federal grant program are governed by federal law and that a State or local law which directly contravenes federal eligibility requirements, or which, in order to accomplish a State purpose unrelated to the purpose of the federal grant, imposes a limitation on federal grant eligibility in an area not addressed by federal law, is invalid under the Supremacy clause of the U.S. Constitution.

King v. Smith, 392 U.S. 309 (1968), involved the validity of an Alabama "substitute father" regulation under which the State denied eligibility under the State administered program for Aid to Families with Dependent Children ("AFDC") (established by Title IV of the Social Security Act) to children of a mother who cohabits with an able-bodied man. The Court invalidated the Alabama regulation on finding that it conflicted with the eligibility requirements of the Social Security Act qualifying children who were deprived of the support of an individual who owed the child a State-imposed duty of support. The Court rejected the State's argument that its regulation was based on the State's asserted interest in discouraging immorality and illegitimacy, noting that the State's policy of punishing dependent children for this purpose conflicted with federal policy as expressed by Congress.

More recently in Townsend v. Swank, 404 U.S. 282 (1971), the Court invalidated an Illinois statute and regulation which disqualified needy dependent children age 18 and over, from receiving AFDC benefits if they were attending a college or university. The Social Security Act required that AFDC payments be furnished to all eligible individuals, and imposed no limitation on the eligibility of children age 18 to 20 with respect to college or university attendance. Citing King v. Smith, supra, the Court held (page 286): ". . .at least in the absence of congressional authorization for the exclusion clearly evidenced from the Social Security Act or its legislative history, a state eligibility standard that excludes persons eligible for assistance under federal AFDC standards violates the Social Security Act and is therefore invalid under the Supremacy clause."

It is however worth noting that a State or local law which implements a federal purpose and is consistent with federal law is valid even if its specific provisions are more restrictive than the minimum standard required by the federal law. An example of such a law was the subject of City of New York v. Diamond, 379 F. Supp. 503 (S.D. N.Y. 1974). That case dealt with the Environmental Protection Agency's right to disapprove New York City's application for federal construction funds because New York City insisted on implementing a very stringent minority hiring affirmative action plan on federally assisted projects. Applicable federal law required compliance with Title VI of the Civil Rights Act of 1964, and with a federal Executive Order requiring a grantee to include an anti-discrimination provision in its contract, and to take affirmative action with respect to minority hiring; but federal law did not mandate provisions as stringent as those contained in the New York City plan. The district court upheld New York City's right to a federal grant, stating that where the federal government has not preempted the entire field to be regulated, the local law is valid unless it conflicts with, or tends to obstruct the purpose of the federal law. In this case the local law was held to be consistent with applicable federal law, even though federal law would have permitted a less restrictive standard.1/

On many occasions federal education grant programs must be administered in accordance with State requirements or limitations. One example of such an accomodation was discussed in Wheeler v. Barrera, 417 U.S. 402 (1974). There it was asserted that State law barred State and local officials from providing on-premises educational services to private school children. Federal law (Title I of the Elementary and Secondary Education Act) provided that in Title I programs (which are publicly administered), eligible non-public school children must be provided services comparable to those provided eligible public school children. The court held that the federal program had to be administered in keeping with the State law and that if State law were ultimately found to proscribe on-premises services, comparable services to private school children would have to be provided through alternative means. Referring to Congressional "aversion" to the "federalization" of local educational decisions, the Court cited section 432 of the General Education Provisions Act, 20 U.S.C. 1232a, which provides in pertinent part:

> "No provision of. . .the Elementary and Secondary Education Act of 1965. . .shall be construed to authorize any department, agency, officer or employee of the United States to exercise any direction, supervision, or control over the curriculum, program of instruction, administration, or personnel of any educational institutions, school, or school system. . ."

The Court did indicate, however, that if the State refused to carry out the federal requirement for comparable services to nonpublic school children, that it could not participate in the Title 1 program.

The question of whether the particular State regulations mentioned by Congressman Michel are inconsistent with federal law would entail examination of those regulations and the applicable federal grant legislation, including section 432 of the General Education Provisions Act, quoted supra, (which applies to most federally assisted education grant programs) as well as federal legislation addressed to civil rights and school desegration. We note that the Byrd Amendment referred to by Congressman Michel (Pub. L. 94-206, section 209) does not affect grants for programs administered by the Office of Education, although similar provisions are contained in Pub. L. 94-94 (the Education Division and Related Agencies Appropriation Act, 1976),2/ which does affect education grant funds.

Our final point is that, in situations exemplified by the Diamond case, supra, where a State or local law accomplishes a federal purpose, our view is that the means of enforcement of such a State law by withholding federal funds would be a matter governed exclusively by federal law. That is, in a State or locally administered federal grant program, a State or local action disapproving a federal grant application or withholding federal grant funds for failure to comply with State law, must conform to enforcement procedures established by applicable federal law. In the absence of federal legislation authorizing the State or local government to take enforcement action, it would be up to the federal government to take such enforcement action.

Federal law does afford applicants and recipients of educational grant funds procedural rights with respect to any such enforcement by the State or by the federal government. Section 425 of the General Education Provisions Act, 20 U.S.C. 1231b—2(c), provides that an applicant or recipient of federal funds in a State administered education grant program who alleges a violation of State3/or federal law in connection with the State's action in disapproving a grant application or in withholding grant funds, is entitled to a hearing on the record before the State Educational agency. (The applicant or recipient is also entitled to review of the State educational agency's decision by the Commissioner of Education for consistency with Federal law.)

Please let us know if we can be of further assistance in this matter.

Theodore Sky
Acting Assistant General Counsel
for Education

Sarah L Kemble

By ______________________
Sarah L. Kemble
Attorney-Advisor

cc: Mr. Barrett
Peter Bouxsein
Darrel Grinstead

Note to Charles Miller

FOOTNOTES

1/ It is the principle expressed by the Dinmond case as well as section 435 of GEPA which permits States to establish their own rules for the administration of Title 1 of the Elementary and Secondary Education Act of 1965 and other State administered education grant programs, provided that these rules are consistent with and further the purpose of the federal enabling statute.

2/ Section 315 of Pub. L. 94-94 provides:

> Sec. 315. (a) No part of the funds contained in this Act shall be used to force any school or school district which is desegregated as that term is defined in title IV of the Civil Rights Act of 1964, Public Law 88-352, to take any action to force the busing of students; to require the abolishment of any school so desegretated; or to force on account of race, creed, or color the transfer of students to or from a particular school so desegregated as a condition precedent to obtaining Federal funds otherwise available to any State, school district, or school.
>
> (b) No funds appropriated in this Act may be used for the transportation of students or teachers (or for the purchase of equipment for such transportation) in order to overcome racial imbalance in any school or school system, or for the transportation of students or teachers (or for the purchase of equipment for such transportation) in order to carry out a plan of racial desegregation of any school or school system.

3/ The reference to State law in section 425 is a recognition that, as discussed above, there are certain occasions where federal grant eligibility may depend on State law.

INFORMATION REQUIRED BY OFFICE OF CIVIL RIGHTS

Mr. **Michel.** We received a substantial number of complaints from the school administrators in my district as to the extent to which the HEW Office of Civil Rights is going in requiring a myriad of statistical information, recordkeeping, et cetera.

That office is even going so far as to require the keeping of records on punishment.

Now, can't we do something to rein in the excesses of that office and establish more commonsense, less costly guidelines?

Secretary **Mathews.** Not only can we, but we have. In regard to the information that we are required by law to keep, and particularly that in regard to discipline, the Office of Civil Rights withdrew those requests for information and worked out a different form in concert with the State superintendents of education and have reissued that in a form that I have the personal assurances of the State school offices are administratively sound and not unduly burdensome.

CRIMINAL SANCTIONS FOR STUDENT AID ABUSE

Mr. **Michel.** In October, I introduced a student aid abuse bill that would place criminal sanctions in the educational code in order to bring a halt to the millions of dollars worth of the fraud that is being uncovered by your Department and some of the news media, and I seem to get some mixed reactions from the Department down there on the issue of criminal sanctions.

Have you got any specific feelings on the need for such sanctions?

Secretary **Mathews.** I think this would be an appropriate point to say to you and to the committee and for the record that we are very concerned about this problem, and that we have transmitted to Congress six separate proposals that would reduce and correct fraud and abuses in these programs.

As to the particular matter of criminal sanctions, until we have given you a bill report on that, which quite frankly I am not familiar with if we have, or if we owe you one; and my statement to you earlier that if we owe it to you, we will get it to you. Right, Mr. Kurzman?

Mr. **Kurzman.** That is right, Mr. Secretary.

MEDICAID ABUSE

Mr. **Michel.** If medicaid has extensive provider abuse in it, now that you know of it, what will happen when it is mixed in with other health programs in a block grant? Won't the abuse just be hidden further and be more difficult to uncover?

Secretary **Mathews.** The current problems with medicaid fraud concern us and we don't want this situation replicated with the block grant. And specific audit responsibilities will be spelled out in the legislation, with most of the responsibility for assuring program integrity assigned to the States, as is the case now. We would retain an overall audit review responsibility.

I would also like to note that we believe that one factor which has contributed to medicaid abuses has been the fact that the program has been open-ended, with the Federal Government picking up a majoritof the costs. This has, in my view, contributed to lax program administration. With the block grant, there would be a set amount of Federal money. We believe this will help lead to tighter controls over the program.

OFFICE OF THE SECRETARY STAFF

Mr. MICHEL. I would like to know how you distinguish between line and staff personnel in the Office of the Secretary. For instance, how would you classify an Assistant Secretary, and then how would you classify a Deputy Assistant Secretary?

Secretary MATHEWS. Essentially, the difference has to do with whether an official directs one or more of the Department's programs. If he or she does, we regard that official as a line official. Others who provide advice or support are staff. Assistant Secretaries can be either line or staff. The Assistant Secretaries for Health, for Education, and for Human Development have program responsibilities and are line officials. The remaining assistant secretaries are staff. To the best of my knowledge, all deputy assistant secretaries are staff.

Mr. MICHEL. Do staff personnel have official responsibility for making policy in your Department, and if so, what is the statutory or administrative authority for this?

Secretary MATHEWS. Staff personnel have no authority for making program policy except in areas where they have responsibility—for example, Mr. Young, the Assistant Secretary, Comptroller, who is here, has delegated authority for financial management. Staff personnel could make recommendations but then it would be the Under Secretary's or my responsibility to make the decision.

As a general rule, the legal authority for making policy is vested in me, except where the statutes vest authority outside the Secretary's office. I would, in turn, provide delegations of authority, by administrative action, to the line or staff components of the Department. The delegations are usually on the basis of subject matter. Our procedures are quite typical of large organizations.

Mr. MICHEL. Do staff personnel negotiate departmental policy with the States as representatives of the Secretary instead of [illegible] personnel in some instances, and if so, what instances?

Secretary MATHEWS. The answer generally is no. There have been instances in the recent past where I have asked at least one staff assistant secretary to negotiate with one or two States. This occurred because we were in a period of transition with respect to appointing a particular line official to head the program about which the negotiations revolved.

Mr. MICHEL. To what extent do staff personnel participate in reviewing and approving grants and contracts in the Office of the Secretary?

Secretary MATHEWS. All contracts desired by officials of the Office of the Secretary are reviewed by a central grants and contracts office made up of staff experts. Grants or contracts for evaluation of the Department's programs are often reviewed by staff of the Assistant Secretary for Planning and Evaluation. Other than this, staff personnel in the Office of the Secretary do not review grants and contracts.

Mr. MICHEL. What responsibilities and legal powers does the Assistant Secretary of Education have that the Commissioner of Education does not have? Do we need both positions?

Secretary **Mathews**. The Assistant Secretary is head of the Education Division, of which the Office of Education is a subordinate office. As such, the Assistant Secretary is responsible for policy guidance and coordination of activities between the Office of Education and the National Institute of Education. The Assistant Secretary also has the role of being the public spokesman for education at the Federal level. In addition, the Assistant Secretary has direct operating responsibilities for the National Center for Educational Statistics and the Fund for Improvement of Post Secondary Education. Responsibility for administering Office of Education programs has either been assigned directly by statute or delegated to the Commissioner of Education. Regarding your question in whether both positions are needed, we indicated in a letter to Senator Beall on S. 2657 just last week that we favored consolidation of the positions, which was one of the provisions in that bill. There were also some other features in that bill which we did not favor, but we did support putting the two offices together.

Mr. **Michel**. How many special assistants to the Secretary are there, and who are they?

Secretary **Mathews**. There are seven special assistants. There names are: Joffre T. Whisenton, Thomas L. Lias, James C. Wilder, Douglas S. Harlan, Roger O. Egeberg, Nancy Porter, and William S. Ballenger.

GRANTS AND CONTRACTS

Mr. **Michel**. How many programs in your Department involve grants and contracts, and how many grants and contracts are let out in any 1 year, by program?

Secretary **Mathews**. About 290 HEW programs are identified in the catalog of Federal domestic assistance which lists activities and services which can be requested or applied for. Almost all of them are grant type programs. I'm not sure we have even made a count of the number of grants awarded although it must be considerable—we generally talk in terms of program levels and what has been accomplished with the resources. The number of grants doesn't tell you very much.

Mr. **Michel**. What is the total dollar value of these grants and contracts by program?

Secretary **Mathews**. I think you will find a comprehensive listing of the programs on the table we have already submitted to the committee—it is over 20 pages long. Some of the items on it—I am reading from it—include: Maternal and child health, $211 million, community health centers, $155 million, family planning $79 million, disease control grants, $33 million, biomedical research grants, $1,219 million, NIH training, $105 million, mental health research, $83 million, drug abuse projects, $145 million, health resources planning, $90 million, health manpower capitation, $120 million, health manpower special projects, $124 million, education grants for the disadvantaged, $1,900 million, emergency school aid, $249 million, handicapped education, $235 million, vocational education, $532 million, adult education, $68 million, basic opportunity grants, $1,100 million, strengthening, developing institutions, $110 million, Head Start, $434 million, and vocational rehabilitation services, $720 million. There are many more, but they are all on the table.

Mr. **Michel**. Where does your review of the so-called sex-pot grant stand at this point?

Secretary **Mathews**. A thorough review is underway to determine whether the project should be undertaken. Nothing has been decided yet.

Mr. **Michel**. Why is it that you undertook a reconsideration of this grant when an Assistant Attorney General requested it, but would not do so when many of us in Congress asked you to?

Secretary **Mathews**. In undertaking a review of this grant we are responding to questions and concerns raised from several sources—Congress chief among them. We are not reviewing the grant again solely because of Justice.

Mr. **Michel**. Initially in response to our expression of concern, you emphasized the need to defer to scientific judgment on such projects. It may be that machinery has been set up for grant consideration which does not include the Secretary, and normally I would agree with this. However, isn't there also a responsibility to watch over the allocation of taxpayer's moneys in terms of propriety, especially when a considerable number of taxpaying citizens are offended and express concern over that decision, even if it may have scientific merit?

Secretary **Mathews**. I can appreciate your views on this, Mr. Michel; but it is my judgment at this time that project reviews at the Secretary's level is not necessary or desirable. It seems to me that there are enough checks and balances in the review process to screen out most questionable projects. And, regardless of how many reviews are made and at what levels, there will always be differences of opinion on the merits or sensibilities of given programs.

SUPPLEMENTAL SECURITY INCOME

Mr. **Michel**. What are you doing to improve the management of the supplemental security income program?

Secretary **Mathews**. Several things are being done. We have just completed a thorough review on the SSI program and are now evaluating the findings of the study group. We have asked for more staff for social security in order to strengthen field training and reduce excessive overtime. Computer programs and administrative procedures are being improved. Redeterminations of eligibility will be made. Overall, we expect that the error rate will be significantly reduced below the current figure of about 24 percent.

When Commissioner Cardwell appears before the committee, he will be able to go into more detail with you on this.

Mr. **Michel**. If I recall correctly, Commissioner Cardwell said recently that there will always be a fairly high error rate in the SSI program because of the complicated nature of the program. Doesn't that experience with SSI indicate that a totally federalized welfare program or health insurance program is also likely to result in many administrative problems and a high error rate?

Secretary **Mathews**. I believe that would depend to a great extent on how much lead time there would be for implementation, the complexity of eligibility standards, requirements for cost sharing, definition of services to be covered and many other variables.

Error rates are likely in any program and the more complex it is, the greater the probability of error.

Mr. MICHEL. What is the dollar cost required to carry out the "fair hearing" requirement for SSI apparently imposed by the courts?

Secretary MATHEWS. I don't have that information. But it is data which social security should be able to provide you with when they appear for their hearings.

Mr. MICHEL. Would not any kind of a guaranteed income program also require a fair hearing when reductions in or elimination of grants are made, thus resulting in substantial administrative costs?

Secretary MATHEWS. The same situation is currently the case with the other social security programs. I would imagine that a analogous situation could occur if the present welfare systems were federalized.

MAXIMUM ALLOWABLE COST

Mr. MICHEL. What is the basic reason for the maximum allowable cost regulations? I understand, for instance, that drug prices have not increased as fast as the overall inflation rate over the past 8 years.

Secretary MATHEWS. Two things are involved. The first step in the MAC regulations is to define how much the Federal Government will reimburse for commonly prescribed drugs—in this case, you might have different costs for different brand names of the same drug. The second stage is to define a maximum cost for a drug based upon the cost of its generic equivalent where that can be established.

Our reasons for publishing the regulations, though, is not because of how fast drug prices have been rising. Rather, it is based upon a uniform reimbursement principle.

Mr. MICHEL. According to reports, I hear it would cost more to administer this program than would be saved in lower drug costs, is that true?

Secretary MATHEWS. Our analysis shows that the potential savings far exceed the administrative costs. In total, we estimate that administrative costs the first full year of implementation would run about $5.5 million, including both Federal and State. Savings would be expected to total between $60 million and $75 million, Federal and State.

Mr. MICHEL. Would such regulations not work to the benefit of the larger drug companies as against the small, since the larger companies would be in a better position to absorb lower profit margins?

Secretary MATHEWS. The intent of our regulations is not to change a physician's prescribing practices. They simply define what we will cover in terms of cost reimbursement. We do not foresee this having much influence on individual drug company sales.

Mr. MICHEL. Why not try such regulations on an experimental basis in a few States first, rather than imposing them nationwide in one fell swoop?

Secretary MATHEWS. Several States already have comparable programs—California and Colorado have, in fact, testified before the Congress, affirming that such a program is satisfactory. Based upon our evaluation of the existing programs, we have concluded that further pilot trials are not necessary.

REVOLVING FUNDS

Mr. MICHEL. Would you list for us all the revolving funds under the auspices of the Office of the Secretary? Does this include the internal revolving fund used by HEW for your various computer operations?
Secretary for his appearance. It's the first time for you, and after only the Office of the Secretary computer center, all HEW payroll operations, the Office of the Secretary printing plant, and similar activities.

Mr. MICHEL. I think with that, Mr. Chairman, I want to thank the Secretary for his appearance. It's the first time for you, and after only 6 months on the job. And in that Department, and I don't know how many times they have said, I don't know how anybody could be down there for 4 years and really know what all is going on, and I think you have acquitted yourself very well today, and we all recognize the magnitude of your job.

I don't think any one of us would want it.

Secretary MATHEWS. Thank you, Mr. Michel. I appreciate that statement.

Mr. FLOOD. Mr. Smith?

SECRETARIAL CONTROL OF DEPARTMENT

Mr. SMITH. Along the same line, Mr. Secretary, you have been there 6 months, and you are No. 11. Have you been there long enough to convince yourself that it's pretty difficult to ever get complete control of that Departmnet?

Secretary MATHEWS. I was convinced of that before I came, Mr. Smith. It did not take a lot of convincing. I would say this though, very often I hear that the issue is one of control. My own judgment is, after having looked at this rather carefully, and rather intensely for the last 6 months, is the more accurate statement is that the Department is not out of control, but in fact, is controlled by a variety of different forces.

As I have just pointed out to you, even I as Secretary do not have control of certain elements of the Department, by law. And I think to get a proper diagnosis on our difficulty, we could refine what we normally say and improve our understanding of the problem we are dealing with if we recognize the fact that the Department probably is under good control, but by a lot of different people.

Mr. SMITH. How do you propose to anticipate hot spots before they get so far along they are burning?

Secretary MATHEWS. Well, with a program that touches 215 million people, that is everybody in this country, and not just once but two or three times, the honest answer is there is no way that you are going to anticipate everything that might happen in the United States.

I think what you want to do, and I believe this is the point of your question, is that you want to be certain that you have such a relationship with the principal line managers that they attend to their own shop. I think that with a large and heterogeneous department that the only way we have found in management science to deal with such a unit is to hold the unit managers accountable for what they do. And to get the kind of communication system between the Secretary and principal management officials.

Mr. **Smith** There was another tool that was used for a number of years in the Department of Agriculture that I think surely deserves a try, and that is the so-called "Inspector General," where he is responsible directly to you, has the run of the Department, discovers what is going on that shouldn't be going on, including conflicts and inconsistencies between different Departments, and reports right back to you that you can head off what otherwise could become embarrassing.

Secretary **Mathews**. Well, we have that under consideration—devices like that—and actually most institutions have for a long time had some form of that.

In our Department the Assistant Secretary for Planning and Evaluation, along with the Under Secretary have responsibilitties very similar to the ones you have described.

We may use a little bit different title, but any large oragnization does have to concentrate on those problems that fall outside of the clear territorial domain of one of its units.

BLOCK GRANTS

Mr. **Smith**. In your statement you dwell quite at length in a number of places on block grants.

Secretary **Mathews**. Yes, sir.

Mr. **Smith**. I agree that some of these programs were splintered too much over the years in the authorizing process. However, you include immunization under preventive help in a block grant. Isn't that one of those kinds of programs that peculiarly do not fall within what we would normally think of as a block grant approach? In other words, a breakout of a communicable disease in one part of the country may not occur uniformly throughout the United States.

Secretary **Mathews**. We do not include in the block grant our principal unit for dealing with communicable diseases which is the Center for Communicable Diseases in Atlanta, which stays as a separate unit.

We are however, trying to give greater leeway to the Public Health Services of States which also concerned with immunization

But as to the general principle, there ought to be a Federal activity to deal with communicable diseases, and we do observe that principle in the retention of the CDC.

Mr. **Smith**. Well, the contribution though is through the Disease Center at Atlanta for health sharing funds, for example, for rubella.

Secretary **Mathews**. Right.

Mr. **Smith**. So that isn't consistent with your answer, is it?

Secretary **Mathews**. These are project grant funds, and I will get you a more detailed answer, but I believe my answer, again a general answer, is correct.

Mr. **Miller**. I might make two points, Mr. Smith. I think the main emphasis on immunization should be on prevention and not after the outbreaks. The States can decide the amount of the health dollar they want to spend on prevention. Second, although the money flows through CDC, the principal agency for doing the work is the State health agency.

NURSING ASSISTANCE

Mr. **Smith.** Now, I noticed in the justifications the same old story with regard to nursing assistance. It's been going on for several years. Last year we appropriated $41,916,000 and now you are proposing a total of $10 million. A year or two ago, the head of one of the Departments even came up here and told us there is no longer a nursing shortage in this country.

You are not basing a reduction like that in nursing assistance on the theory that there isn't any nursing shortage, are you?

Secretary **Mathews.** No; and as a matter of fact, we have some new initiatives in training for nursing under the Health Manpower Act that represents a significant, I think, initiative.

I reported that initiative to you on page 14 of my testmony.

Mr. **Smith.** That was related to that attempt to make them serve in areas that are said to be deficient.

Secretary **Mathews.** Right.

Mr. **Smith.** Is that right?

Secretary **Mathews.** That is correct.

Mr. **Smith.** Well, of course, as far as nurses are concerned, they are deficient in all areas of the country. Right in Des Moines, Iowa, with the biggest hospitals in the State, and the place where presumably nurses would be easier to recruit, they have shortages in all of the major hospitals right now.

Secretary **Mathews.** I would be glad to give you the figures that our Health Division used in making its projections. I am sure you want to have those for 1976.

Mr. **Smith.** I will tell you what I think you get into here.

Secretary **Mathews.** Yes.

Mr. **Smith.** It may not be quite as bad as it was a year or two ago, but the very structure of the health care field is such that as the budget is developed, as programs are administered, medical doctors are at every stage, and then somehow they filter out some of the needs of the nurses. I don't think that their needs and their relative importance really is felt in the decision making process.

They are the first thing to be dropped. Their kinds of health care are the first things to be relegated to the back burner, and certainly we need more nurses, and if we are ever going to be able to have additional health care, I don't see how we can do it until we have some system whereby doctors depend more upon nurses to deliver some of the health care they are capable of delivering.

Secretary **Mathews.** Mr. Smith, I think I understand exactly what you are saying. The last thing I did as President of the University of Alabama was to create a school of nursing to work with doctors in rural areas, or create it with the assistance of the State legislature, and I am quite sensitive to the problems that you describe.

Mr. **Smith.** I believe there is even a resistance again on nursing assistance, isn't there? That's an annual exercise.

Secretary **Mathews.** Yes, that is true.

Mr. Smith. We put in the money, the Congress overwhelmingly expresses its desire, and then up comes the rescission.

Secretary Mathews. Yes. But I would say to you, as I said with the doctors, there is no evidence that increasing the aggregate number of nurses in the country will attend to the critical need that we have in certain areas of the country.

That is, the figures that I have seen again and again illustrate the maldistribution of these resources and for that reason we have quite frankly put the dollars that we have into the priority we have with the problem of maldistribution, and in particular on the necessity for upgrading the nurses, giving them the appropriate training they need so they can, in fact, have the partnership with the doctors that they need to have, in order to increase the quantity and quality of health services.

Mr. Smith. Put it another way, there is no evidence that increasing the number of nurses in that area wouldn't help us there.

Secretary Mathews. As a matter of fact there is that dilemma. That is, we have both increased the aggregate—we have gone through a period of time when we have seen dramatic increases in the aggregate number of physicans and nurses—and at the same time have increased the maldistribution problem.

Mr. Smith. The census shows in the last 5 years there has been a movement from the cities back to the rural areas and most nurses practice where their husbands live.

If a movement back to rural areas continues, certainly educating more nurses is going to increase the number of nurses in rural areas.

Secretary Mathews. I can tell you coming from a rural area, we haven't quite felt it yet, and there are a number of States where there are enormous problems of maldistribution that still show up in the field.

STUDENT ASSISTANCE

Mr. Smith. Now, on an area you have dealt with quite extensively, higher education, let me ask you this question.

Suppose there is a needy student who gets the maximum BOG, $800 or they can use $1,400 if they want to as the amount. He also receives a scholarship, that may be even as much as $1,000 more for scholarships, so he is up now to $2,400. He gets some work-study, $600. Now he is up to $3,000.

Where is he going to get the balance out of this mix that you have proposed here? His father doesn't have a bank account at the bank, he can't get a guaranteed student loan as a practical matter, and needy students are not getting those kinds of loans.

Where is he going to get the additional money if we don't have a direct loan program?

Secretary Mathews. I am not certain he is not eligible for some of the loan programs we have.

Mr. Smith. He is eligible but, in fact, the banker gives them to who he wants to give them to, and they don't give them to these most needy students.

Secretary Mathews. I believe if you look at our figures on the income distribution of students in the GSL program you will find there are a number of people in the lower-income brackets getting those funds.

Mr. Smith. I don't care what the figures show, I know students that need money like I am talking to are not able to go to banks and get these loans.

One after another will tell you this and the bankers will tell you that now. In fact, one of the bankers that has been making loans in Iowa told me the other day he is going to stop making them to anybody except where the parent has a substantial amount of money on deposit in his bank, because it takes so long to—if they default on the loan—get the money out of the guarantee account, that he loses enough interest on that that it offsets any gain he had on the loan.

So he is going to stop it altogether, let alone helping the needy student.

My point is year after year this committee puts in the direct loan money because that is the program that is working, we are getting the money back, we are using it a second time.

It seems to me that's the most successful student loan program or student financial assistance program in the whole mix, but that's the one that the Department proposes to be eliminated all of the time.

Secretary Mathews. Well, I asked that very question, because we are contending that we are shifting the money from that program to the BOG's program and the GSL program and I am told that more disadvantaged students, a relatively higher percentage of disadvantaged students, are helped with BOG's money than NDSL money.

Mr. Smith. I defy anybody to prove that BOG's help middle income. Obviously, it helps them, and they were not helped enough out of the other mixes that we had before. But it doesn't do any good for a needy student who needs $3,000 to be able to get $1,400 out of the BOG's, if there isn't somewhere to get the balance. He still cannot attend school.

The neediest students can't use BOG's as a substitute for everything else they have and all of the knowledgeable financial aid people I have talked to at the universities tell me the same thing, that without direct loan programs it is the neediest students who are not going to be able to go to school.

Secretary Mathews. It was just the opposite testimony that convinced me we had a sound recommendation, because a larger percentage of needy students get BOG's than NDSL's.

Mr. Smith. But a larger percentage of a group getting a certain kind of a program doesn't tell you what happens to the smaller percentage. They are eliminated pretty much.

Secretary Mathews. Well, it does say if we move dollars from this program, that is not particularly advantageous to the poor student to a program that is especially advantageous to them, it's a reasonable argument.

Mr. Smith. The point is that the needy students are the ones that really must receive adequate financial support.

Secretary Mathews. I would agree.

Mr. Smith. And the financial aid offices say, "Look, we go through all of the programs, and then some parents can help, but they still have students who can't get enough help. That's when they must use the direct loan funds." That's where they use them and they are not required to distribute them on the basis of the same number of dollars to each student. They can just fill in the balance, you see, with that very much needed money. To shift this money to BOG's disregards the needs of the neediest students.

It just seems to me we are going through the same old thing again this year. I think that especially coming from the field of higher education like you have, you ought to have another visit with your financial aid officers and take another look at that.

Secretary MATHEWS. I would dare say I am reasonably familiar with the financial plight of students, and for that reason, and, I am quite aware of the very good impact that the BEOG's program is having in the field.

Mr. SMITH. That is all I have.

Mr. FLOOD. Mr. Patten?

Mr. PATTEN. Mr. Chairman, I would like to welcome our new Secretary, and I wish him happiness in his term of office. You should be happy. You do your work well, and you ought to get to heaven.

Secretary MATHEWS. I think that is only a just reward for this job.

CONGRESSIONAL ACTION ON BUDGET

Mr. PATTEN. You have some people in your Department who have compassion for their programs and they are right with it. And I am quite sure they feel they render a service just as much as any monk.

Many years ago during the depression I remember two out of every three men were out of work. My suicide rate was very high. Much higher than recorded because there was no undertaker that ever reported a suicide. He wouldn't get any more business. That's forbidden, so you don't see the correct figures on suicides.

People were really hungry. As we sit here today, even since you were born, even since 1953 my country has 60 million more people.

Now, when I came to Congress the Federal Government collected $93 billion. This year, let's round it out to say $400 billion. And do you know the nice part of it is this: I have never done anything to cause inflation. All I ever did here was cut taxes. And cut appropriation bills.

Does that surprise you?

Secretary MATHEWS. It heartens me.

Mr. PATTEN. I mean us collectively, the Congress.

Do you know, and this is no question, I will document it for you, we gave President Nixon in his terms of office $30 billion less than what he requested?

Secretary MATHEWS. Yes.

Mr. PATTEN. And the Chairman told us in the House the other day that on the current budget we gave President Ford $4 billion less than he requested. So you can relax, we won't go over the budget.

But we are going to collect next year, they all tell us, $40 million more than last year.

Now, our gross national product, wages and the like, have reached an alltime high. We are talking of a $1,700 billion gross national product.

So I will tell you what you do, to prove that, I only cut taxes. I cut the income tax 10 times since I am here.

I cut out the tax on cosmetics, pocketbooks, telephones, the 5-percent tax on automobiles. All I did was cut taxes since I am in Congress and I am quite proud of it.

You figure up your income tax, and figure the same income on 1964 form, you see, and you pay the Federal Government 25 percent less than you would have paid the year I came to Congress. Isn't that lovely?

Secretary MATHEWS. It is.

Mr. PATTEN. So all of my banks have 10 times as much money as they had 10 years ago. Exxon in my district did $35 billion. I mean 10 years ago this was inconceivable.

I have 18 oil companies.

In 1964, Johnson & Johnson did $100 million worth of business. Last year they did $2 billion, 20 times as much. In fact, they have made $250 million on their foreign trade.

Remember the English used to say give 10 percent to charity.

Secretary MATHEWS. Yes.

FEDERAL BUDGET PRIORITIES

Mr. PATTEN. Well, on that rule of thumb, how are we doing as a nation? As you come to this, this is our—what is the word they use—tithes, something like that. You are supposed to give about 10 percent.

Secretary MATHEWS. I believe in the President's budget about 45 percent of that would go for individual benefits, income security, so roughly half of the budget that the President proposes is for people.

Mr. PATTEN. Wait a minute. You are mixing me up, I was talking about 212 million people generating a gross national product of $1.7 trillion, you see.

Secretary MATHEWS. Right.

Mr. PATTEN. Now you come back and confine yourself to the $400 billion the Federal Government will collect.

Now let me give you a significant factor.

Secretary MATHEWS. Yes, sir.

Mr. PATTEN. On January 1, 1976, we started collecting an additional social security tax that we imposed by H.R. 1 and under H.R. 1 we set up provision for the SSI, for the blind, et cetera.

Secretary MATHEWS. Right.

Mr. PATTEN. And eight other categories. And the Federal Government collected $25 billion. So that if you take our budget which was $33 billion, and realize today you are talking of $40 billion, you see, but we are going to collect $25 billion we didn't collect before in 1975, we have got $25 billion more in the Treasury, and your budget, if you take out these items under social security, and just talk of our regular items, leaving out the trust funds, you are far under the budget.

The chairman said $2 billion. I figure $8 billion. You have abolished my model cities, you abolished HUD, you abolished the poverty act. But from a dollar point of view, the Treasury did take in last year under additional social security taxes $25 billion.

But, I figure out you only spent $7½ billion.

You see, for SSI, and increased medicare and those programs. So that actually the Treasury does not have to raise as much money to finance your Department as they did some years ago. I think they have a lot of cash in the bank and if you compare the two figures, add the $25 billion additional social security taxes, we had $33 billion before, now you have $40 billion, you are spending $7 billion more, but you are taking in $23 billion, isn't it nice? So that the Treasury is not being murdered by the HEW budget as I see it.

The trouble is you are throwing in SSI and other trust fund items that we raised the money to finance. And if you only take education and our regular health programs not under the social security program, I think you have really cut HEW substantially.

Secretary Mathews. No. In fact, we are proposing——

Mr. Patten. Isn't it beautiful, the country is really great, the sun is shining, and all is right with the world.

Secretary Mathews. Well, I think it was fine. I just didn't know who to thank for it.

Mr. Patten. Just think, 200 years ago, we celebrate George Washington's birthday in our house for a reason next Sunday, we didn't celebrate it last Monday, but I made a few speeches and they loved it, but poor George 200 years ago, in my State history, it says not one-third of the people were with him on the Revolution, and there he stayed this time of the year, after Christmas he was at Valley Forge, ill-fed, tattered Army. He had no Constitution.

That came in 1781, that came later. They had no revenues like you had then. The American people are just gorgeous. And poor George, standing there at Valley Forge in the cold weather, with the poor soldiers and this is what we are celebrating. Right? Or 200th anniversary.

Secretary Mathews. Right.

Mr. Patten. They said they were hungry. If we are to draw up a little litany as Americans, what would be No. 1? I think probably freedom from hunger. If you can produce the food and if you can have other production in the country like ours, at the rate of $1.7 trillion.

Secretary Mathews. Yes, sir.

MEDICAL EDUCATION

Mr. Patten. The first two things, freedom from hunger and freedom from want—we are in our anniversary year. As a Nation we are free from hunger, we are free from want and I think it's all beautiful, you see.

Now, when I came to the Congress, never in its history did the rich State of New Jersey ever have a medical school.

When I was working for 50 cents an hour, I wanted to go to college. A lot of people say to me, "I paid for my kid to go to school and you ought to pay for yours." Is that your philosophy here?

Secretary Mathews. No, sir.

Mr. Patten. They never had a medical school in New Jersey until I came to Congress. I sat around when I was there. We realized our biggest trouble was mental trouble. I hate to put a figure on it.

In New Jersey we felt rather than sending many people to mental institutions, we should do something as a municipality to help our people who are sick. But we never did a thing until I passed the community health facility under Federal money. Up there, my alcoholics, drug friends, the people who have all sorts of problems, go there. Everybody tells me the community center in my city, we call it the community health center, everybody says this is a good government, it is a step forward. Now, they claim they rehabilitated many.

In your justification, your state you rehabilitated 374,000 under your programs. Do you get the point I am making?

Secretary MATHEWS. Yes, sir.

PHILOSOPHY OF REVENUE SHARING

Mr. PATTEN. Everything is relative. I am not overawed by your budget, by any means, but I have a lot of respect for some of these programs which you have aborted and I am unhappy, very unhappy.

Let us talk a little about your fundamental philosophy as to revenue sharing. Thank God, my city received it. What do you think my city did with it? It all went in as anticipated revenue to maintain the tax rate. Not one penny went for any health, educational, or any other program under revenue sharing. You know what they did with it in California? I read one time they could declare a dividend. They used it purely as cash receipts to balance the budget.

The military cries they can't get doctors. We voted a new program, in many areas they have to go to the local community to receive medical and dental care because the Army doesn't have the doctors. But you said something in your presentation that doctors are no problem; we need not worry.

In regard to your other grants, you start right off under health. The first item, you have abolished my community health facility. No. 2, the public health hospital. We have Seaview at Staten Island. We had this vote time and again on the floor. We put these things back. I was not going to come here this afternoon, but I just thought we ought to talk over as friends because everybody has such a high regard for you.

Secretary MATHEWS. I am glad you had the opportunity.

I am glad to report to you that what you think we are doing is not what we are doing. You are right, it would be very wrong to go back to 1930 or 1950. As to the block grants, there will be serious prohibitions against diverting this money to other purposes. There will be very strict insistence on this money going for the general mandates which you in Congress placed. There will be a requirement that such things as mental health be considered.

I would be equally disturbed, I think, if I thought we were just going to dump these programs on the States without any guidance as to the national mandates.

Mr. PATTEN. This is the greatest country in the world. I will just have one more question. When we look back at Rameses and King Tut, those fellows had the slave labor build big monuments. The people came up from all over to see the monuments King Tut made, which were dug up recently in our lifetime. It was the most useless WPA project I have ever seen in my life.

The Greeks built the Parthenon with slaver labor. That is what the booklet which they showed us during the tour said.

We were in Cameroon. The leader said you are an old man at 38; your life expectancy is 38 years of age.

You can be the greatest ambassador, greater than Kissinger, you have it within you, utilizing the wonderful food we have, our health capability. We can win over the people of the world by extending assistance in this area.

Now, this budget has a $12 billion increase for guns. I know you don't want to hear it. I am comparing it with the other budgets, but my HEW for the mentally retarded, the other programs are being cut. I don't like it, Mr. Secretary. I don't think this is the way we should go as a moral people. We should be the beacon in this field. The work which was started up in NIH and other departments for the people, should be carried on.

You be the man you can be, you dedicate yourself to HEW, you will be one of the greatest Americans who ever lived.

God bless you and I hope you succeed.

Mr. FLOOD. Mr. Early.

BLOCK GRANT FUNDING

Mr. EARLY. I am concerned about the budget, Mr. Secretary, when you state in your block grant approach you are going to shift to give the local States and local governments more flexibility. As I look at your funding, you will give them the flexibility but not the money.

Secretary MATHEWS. In all the block grants we are proposing, the money is equal to what was recommended before and in most cases, with increase, that is in medicaid, we would add a billion dollars there——

Mr. EARLY. But wasn't medicaid funded at $9 billion last year?

Secretary MATHEWS. $8.3 billion.

Mr. EARLY. Then you added 16 block grants in there and you will bring the funding up to $10 billion.

Secretary MATHEWS. $10 billion, yes.

Mr. EARLY. What was the total of those block grants last year?

Secretary MATHEWS. Of those individual items last year, sir, it was $9.6 billion.

Mr. EARLY. Just 9 billion 6.

Secretary MATHEWS. So we are $400 million over. The same thing is true in education.

Mr. EARLY. Is it true, though, as far as the same amount of money going into the communities, of course, you are taking into consideration inflation, normal growth expansion, you are also going back and eliminating the State matching. So, they will end up with less moneys. If there is any trend in State government, it is going toward—Mr. Patten made his whole point to—just holding the taxes at the rate they are.

Secretary MATHEWS. As I pointed out earlier in the day, I think it is significant to note before we had State matching, the States were putting in $13 billion—13 out of every $100. After 10 years, they are still putting in 13 out of every $100. There is no anticipation the States will suddenly cease in practices they have been in for a long time.

Mr. EARLY. I can't accept that, Mr. Secretary. My State, which is the only one I can use as an example, and I was vice chairman of the

Ways and Means, they have cut back drastically on all the programs in your budget because there are no moneys available. With this year being a little unique, a chairman could override a veto or get a supplementary budget. This year, there will be no moneys so when you get your initial thrust with the initial budget, when you are running short of money, it will be a question of cutting programs.

Secretary **Mathews**. Under matching law if a State has to cut back, the Federal Government has to cut back, if you take out the matching requirement there won't be any decrease.

FUNDING AUTHORITIES FOR BLOCK GRANT PROGRAMS

Mr. **Early**. In your statement, pages 5 and 18, you say: "In other words, we are not asking you to wait to appropriate the funds until the legislation has been determined."

On page 18, you say the same thing as to pending legislation change.

What happens if the legislative change doesn't go into effect, which is probably what will happen.

Secretary **Mathews**. Then we would be assuming appropriations under current legislation.

Mr. **Early**. But you are appropriating on the pending legislation, not the present law.

Secretary **Mathews**. No, sir, under the present legislation.

Mr. **Early**. Refer to page 18:

> Legislative authority for virtually all of the programs under this appropriation expires at the end of June 1976. However, the budget contains appropriation requests based on the administration's recommended legislation.

Secretary **Mathews**. In that case you have expirations.

Mr. **Early**. But the expirations are probably higher funding than the legislation.

Secretary **Mathews**. That is in higher education, you must have new legislation, your legislation expired 2 years ago.

Mr. **Early**. But usually when revenue sharing, which expires in December, expires at the same rate. No one in the Congress thinks we will stop our appropriation to education. But you are funding on the incoming proposal.

Secretary **Mathews**. We are requesting funding on the basis of proposed extension or new legislation, where legislation has expired. Funding would continue to be provided, of course, under the continuing resolution while Congress considers our proposal. But where legislation has not expired, we are asking for funds this year under current law for the first time even though we will come before you very shortly and make proposals to put that money into block grants.

Going back to the point as to what happens if the State is caught in a fiscal bind and has to cut back, it will be worse than it is under our proposal because the matching grant causes a triggering. They would lose the Federal share in that case. This wouldn't happen in the block grants—the State here might cut back but there would be no loss in Federal funding.

Mr. **Early**. It is hard for me to find anything where there is no State participation. With your program, they just won't implement the program. If they get a block grant, they take what the Feds give them, and that is exactly where they will cut off the spending. As Mr. Patten said, revenue sharing was never intended to be spent where it is spent. In Massachusetts, the State's share is used almost entirely toward indebtedness.

Secretary MATHEWS. We are not proposing revenue sharing. We are proposing block grants which earmarks for certain areas. For instance, in the matter of health, there is a mandate that States spend a minimum of 5 percent for community and environmental activities such as community health centers.

Mr. EARLY. Mr. Secretary, that is very idealistic and unrealistic. That same thing was in revenue sharing. But everybody knows the rank and file are concerned with tax rates. Again, it is the minorities and the poor who are going to suffer, the same ones who will be suffering under this program.

Secretary MATHEWS. As a matter of fact, we have provisions in the block grants which would target this more on the poor and minorities than is true under the present legislation.

Mr. EARLY. Once the cities, States, and towns get their hands on the money, you are not going to dictate the use of the money you will see more current expenses incorporated into what you want them to do and that will satisfy the Federal requirements. It is extremely dangerous.

Secretary MATHEWS. If you will look at the specifications on the block grant you will find a vast difference.

Mr. EARLY. Mr. Secretary, for every specification you can show me, I will show you a regulation which is in HEW which is counter-contrary to that.

Secretary MATHEWS. I hope not.

PROPOSED PHS HOSPITAL CLOSINGS

Mr. EARLY. On the closing of these eight institutions, Mr. Secretary, it is your opinion that the States in the local health planning agencies have to approve?

Secretary MATHEWS. We have to notify them. There is a law we have to notify them. We do have to have concurrence of the communities, of course, if they are going to accept them.

Mr. EARLY. Well, I understand, amendments to the Military Procurement Act require no existing hospital facility can be closed without the approval of both local and State health planning agencies.

Secretary MATHEWS. Yes.

Mr. EARLY. Of these eight institutions, have you gotten the approval of all agencies?

Secretary MATHEWS. As soon as we set the budget up we will contact the States.

Mr. EARLY. I would suggest you don't have it from my State.

Secretary MATHEWS. We can't ask them until we present the budget.

Mr. EARLY. Why couldn't we ask them before funding?

Secretary MATHEWS. They have funding now and will have under this proposal. We are not proposing to end the funding.

Mr. EARLY. After 1977 you are.

Secretary MATHEWS. But in the 1977 budget, we propose to fund them.

Mr. **Early**. But I would have thought you would have gotten their approval to close it and with that they would just say it will be open for 1977, then it is closed. I would think you would get that approval before this proposal.

Mr. **Young**. If we don't get the approval, in accordance with the law, these hospitals can't be closed.

Mr. **Miller**. We even have to get authorization in legislation from the Congress before we can close them.

Mr. **Early**. You are saying that you are making 6,500 employed people unemployed. And there is no place for them to go. I just saw the House override a veto on the public works bill to get people working and here the administration is saying we are going to lay off another 6,500.

Secretary **Mathews**. Most of those come out of Public Health Service hospitals. They would be transferred to other entities of government.

Mr. **Early**. I disagree totally with that. Because you are using the assumption there are some unused beds, all those private hospitals are trying to control expenses so they will try to follow the premise of fewer people doing more things. Those 6,500 people you are putting right out on the street with no place to go except to unemployment.

Secretary **Mathews**. I would think in the case of transfer, where a city or State keeps up a hospital they will have to have personnel. We propose to transfer these hospitals where we can to local communities. This is true not only in the case of these but also Saint E's.

Mr. **Early**. There is a facility which has only 79 beds occupied. It is a 120-bed hospital in my area. The city will not absorb it, and they will not take over the facility nor those employees.

Secretary **Mathews**. This might well be true if you are in a city where you have extra capacity.

Mr. **Early**. I have to assume everyone of these facilities is in an area with extra capacity.

What you are saying is, you will save on the Federal level but any way the public looks at it, there will be an increase.

Secretary **Mathews**. Let us assume you have more capacity, you don't need the hospitals. If that is true, you are going to reduce total expense to the citizenry as a result of having maintained x number of hospitals who will only have to maintain x minus 1.

Mr. **Early**. I don't think that will happen, you will find it will be a reduction any way you want to go. I am concerned about the 6,500 jobs. This administration says we are going too fast in solving unemployment. They are doing their utmost to increase it.

Secretary **Mathews**. That is not an immediate 6,500, that is in 1977.

AID TO HIGHER EDUCATION

Mr. **Early**. I know you are a former president of a private institution——

Secretary **Mathews**. Public.

Mr. **Early**. All the privates say "leave us alone." I find they mean stop aid to public education.

Secretary **Mathews**. Well, you may have one spokesman in your community who says that but I know that is not what private educators overwhelmingly say. They are not arguing there should be no public education.

Mr. **Early**. No, they don't dare say they don't want any, but they are certainly going in a back door. If you look at the student enrollment, you will find the ones who go to the University of Massachusetts are the working guys' children and the minorities. It is only recently that the privates have given some aid to the minorities, and they are doing that only out of self-defense. This is a total retrenchment on public education. These cuts you have in education.

Secretary **Mathews**. We are proposing major increases.

Mr. **Early**. As the President says, let the private sector do it. I suggest your budget reductions are saying the same thing.

Secretary **Mathews**. No, sir, I am here advocating a budget that is 10 percent over fiscal year 1976. I am advocating a total HEW budget that represents 35 percent of the total Federal budget, up from 34 percent in fiscal year 1976.

Mr. **Early**. But in your colloquy with Mr. Smith as to scholarships and aid. I know from what I have witnessed over the past 12 years in State government, what he is saying is a realistic approach. Your reply is how it should work on paper. The banks are not giving money to the poor, the minorities, and the ones who need it the most.

Secretary **Mathews**. But as to the major scholarship program which you recommend, most of the money, over $1 billion of it, is for the BEOG program, which is a direct allocation, and it takes into account their needs.

Mr. **Early**. Mr. Patten suggested this budget was $8 billion short; the chairman said it might be $2 billion short. I am sure we won't be able to correct it no matter how short it is, and I am not sure it is what the administration wants.

Secretary **Mathews**. If you look at my total budget, I am advocating more money for the Department. I would admittedly recommend it be spent in different ways and others be increased that you may not care to increase.

AFDC ERROR RATE

Mr. **Early**. I think most of the programs you have cut back, as you know the Congress is going to fund them an increase in your recommended amounts.

On your AFDC, you are suggesting the error rate is 24 percent.

Secretary **Mathews**. The error rate for the States is 31.

Mr. **Young**. Way back, it was as high as 42. Putting in the quality control system, it dropped. The target is 13 percent.

Secretary **Mathews**. Now, the program we administer, the SSI program, which is almost a mirror of the program they administer, our error rate is a little over 24 percent. We project it to drop to 15 percent.

Mr. **Early**. With respect to your error rate, how much money are you presently withholding from Massachusetts?

Secretary **Mathews**. In the social services program, I don't have the exact figure on Massachusetts, but there is roughly $2 billion in total, although that is not the State of Massachusetts by any means.

Mr. **Early**. Would you supply for the record the amount of money or any amounts being withheld because of the error rate and will you stipulate any other reasons for withholding money from the State of Massachusetts?

Secretary **Mathews**. Sure.

[The information follows:]

At the present time, no Federal funds are being withheld from the State of Massachusetts due to excessive error rates in the AFDC program. The Social and Rehabilitation Service (SRS) is reviewing error rate data for the first 6 months of fiscal year 1976. If the error rates exceed the tolerances, Federal matching of expenditures above the tolerances would be disallowed. Final data will not be available until late spring, and disallowances—or "withholding"—will not take effect until the first quarter of fiscal year 1977.

In other public assistance programs—for example, medicaid, social services, State and local administration costs—States have made claims for Federal matching which the Social and Rehabilitation Service has found reason to question. When this occurs, SRS defers payment of the claim until its allowability can be determined through a review of State records. At the present time, approximately $58 million is in various stages of deferral review in Massachusetts. Nationally, the total amount of State claims in deferred status is $2.2 billion. It is impossible to predict how much of this amount will ultimately be allowed.

OFFICE OF INVESTIGATIONS

Mr. **Early**. Mr. Secretary, I have a problem with your Office of Investigation. I was involved in a State where welfare was administered by the cities and towns. The cities and towns had a hue and cry to get it off their back because of the tax burden. They shifted it to the State, which I opposed because I did not think centrally they would be as familiar with it and a lot of other reasons. I see now as far as an Office of Investigation, I see the only way you can administer the broad programs you have is through local communities. Now, I am going counter to my original comments as to grants. Your Office of Investigation, you told Mr. Michel, is 70 people.

Secretary **Mathews**. That is the new Criminal Department. The total number of people we have checking what we do, we ought to also include the roughly 900 people who audit. So we have a force of roughly 1,000 people.

Mr. **Young**. In the medicare program, I think people have a tendency to overfocus on the fraud end of the business. If you don't put in good control, front-end control, you will never get on top of the real big problems. It is true that if your management system is well designed and well managed, you prevent most of what we call abuse of funds.

Mr. **Early**. I think the news media certainly illuminates the fraud and brings it out of balance from what it is. But the only way you are going to control a live program is by local controls. The local police are familiar with both the problems and the people.

Secretary **Mathews**. What I should have added was that those 970 people are dispersed locally. You can only be effective at the point of the administration's program. They are dispersed to local levels. But the reason I have put them under the Secretary is, one, I created it, and, two, the great interest and concern that these issues have caused; I thought it was a way of indicating my own interest and support of this new venture, but I won't propose to operate them centrally.

Mr. EARLY. When you disperse them you are going to disperse 70 investigators, that's roughly 1 for every State. The one that goes to my State will spend a whole year finding out where the 351 cities and towns are. I suggest there is no way he can find out anything.

Secretary MATHEWS. If he had to do it alone, you are right. And if you saw that individual apart from the audit agency or of the regional staff or the regional AFDC staff, we would be alone but we have in the city of Boston a staff of around 10,000 people, maybe more. So he wouldn't be alone.

Mr. EARLY. If there would be one thing which would be constructive, it would be the fact that the State has to be educated. We could never cut any Federal program in welfare because one of HEW regulations under Mr. Weinberger was that you can't spend any less on a program than you spent the previous year. I want to know how that would produce efficiency.

Secretary MATHEWS. Well, that is the matching requirement and that is what we propose to eliminate.

Mr. EARLY. I could have cut it considerably if I did not have that hanging over my head. Almost one-half of the State budget was welfare. We can't cut it because the Federal bureaucrats won't let us cut it. I don't say we have to get the money back in block grants, I don't think it is going to work the way you intend but I admire your intentions. But if there is some way to educate the House and Senate Ways and Means Committee on what they can do and what they can cut the States could provide the same service at a less amount of money. It is a lack of communication between the States and Washington.

Secretary MATHEWS. In fact, I am meeting with a group tomorrow on this matter.

Mr. EARLY. I am very new on this committee, very fortunate to be on it. I am just out of State office and I am going to chase your office on the matter of making our State pay less to get more. Have you removed the regulation that any State which spends less is not eligible for an increase?

Mr. YOUNG. I know in the SSI program, there is congressional law that you can't spend less on your State supplement.

Mr. EARLY. That was the hold harmless provision. I am speaking of the regular general welfare regulation.

Secretary MATHEWS. I will check into that. I don't have the data on it at this time.

Mr. EARLY. Will you let me know? From your comments, I would think, if anything, we have to go for reimbursement formulas where we give cities and towns incentives to be efficient.

Secretary MATHEWS. My impression is that it is legislatively required, so I may come back to you with it.

Mr. EARLY. Mr. Secretary, I am going to tell you I think HEW has done a poor job in the past, and I think the Congress has done a poor job in the past. I don't think anyone has done a good job, it is a tough problem, because it is such a big budget, but I am not looking to blame you or your organization, because I think there is enough blame for all of us. I just want to see us look forward and not look back for somebody to blame.

Secretary MATHEWS. Sure. I think that is very appropriate.

Mr. **Early**. Thank you very much, Mr. Chairman.

DISPARITY AMONG INSTITUTES

Mr. **Conte**. Mr. Secretary, I have for many years been enthusiastic about the work of the National Institutes of Health. I think they are doing a fine job. Yet somehow the disparity between some of the Institutes seems to be growing every year. I would hate to see some of the Institutes be neglected. Do you feel that this is happening?

Secretary **Mathews**. No, in fact I think we are partially redressing past imbalances by giving more of the increase in the research dollar this year to institutes other than Cancer and Heart.

NIH STAFFING

Mr. **Conte**. I noted that you propose elimination of a total of 512 positions at NIH for this year. Is it not true that some of the Institutes such as Allergy and Infectious Diseases and General Medical Sciences are understaffed already?

Secretary **Mathews**. I am not sure what the specific numbers are, but that sounds about right. Basically what those numbers represent are the new positions which Congress added in the 1976 appropriations bill. We did not include them in our 1977 request.

I have found that most program agencies feel they are understaffed and I would imagine that those two institutes share that view. It seems to me, though, that you have to look at NIH staffing as a whole—they have about 11,000 employees. I am sure additional positions for new workloads could be justified, but better utilization of existing staff could also be accomplished.

INCREASED STATE OBLIGATIONS

Mr. **Conte**. Much of the decreases over last year are based on increased contribution by States. How much more will each State have to contribute on an average percentage basis in order to maintain the current program level?

Secretary **Mathews**. We do not have that information at the present time; but, it was pointed out earlier this morning that our 1977 request is about $2 billion less for controllable programs than 1976. I would guess that about half of that is in health and education service programs where we provide funding to the States.

SOCIAL SECURITY FINANCIAL INTEGRITY

Mr. **Conte**. If we are to believe anything that has come out in the papers it seems not only that the social security program and supplemental security income program are in deep financial trouble, but also horribly mismanaged. I have had some pretty disheartening cases come to me from my constituents. What would you suggest as far as improving these systems?

Secretary **Mathews**. That also concerns me and Social Security Commissioner Cardwell. And, we are taking a number of steps to improve the situation. We have asked for 2,000 new social security jobs in order to increase field training and reduce excessive overtime. We are improving administrative procedures and the computer systems and other things. In SSI, for example, we expect that these improvements will result in the error rate dropping from about 24 percent to 15 percent.

NHI CONTINGENCIES

Mr. CONTE. Has HEW developed any contingency plan to prepare for some form of national health insurance should it be enacted?

Secretary MATHEWS. Various kinds of planning are, of course, going on. But, because the health insurance proposals that have been introduced are so diverse precise contingency planning would be nearly impossible.

EDUCATIONAL TV

Mr. CONTE. What will be the thrust, if any, toward elementary and preschool education television programs? I noticed that the request for such ventures as Sesame Street and the Electric Co. are significantly lower.

Secretary MATHEWS. We have been funding those activities for several years and we feel they are first rate but the Administration doesn't believe that the Federal Government should continue subsidizing their costs to the same degree as previously.

READING IS FUNDAMENTAL

Mr. CONTE. What plans, if any, do you have for funding the reading is fundamental program?

Secretary MATHEWS. We are asking for $12 million for the right to read program in total. Our plans did not include funding that activity originally, but funding for this program is currently under review by the Office of Education.

PROGRAMS PROPOSED FOR TERMINATION

Mr. CONTE. Would you provide for us a listing of the programs you are proposing for termination and phaseout?

Secretary MATHEWS. Yes; we can do that.

[The information follows:]

Programs Funded in 1976 Proposed for Phase-Out in 1977

	Revised 1976 Budget	1976 Appropriation	1977 Budget
Health Services			
Comprehensive health grants to States	67,500,000	90,000,000	---
SIDS information dissemination	200,000	2,500,000	---
Hemophilia treatment Centers	---	3,000,000	---
Hypertension	---	3,750,000	---
Home health services	---	3,000,000	---
ADAMHA			
CMHS operations (new centers)	---	53,500,000	---
Rape prevention	---	3,000,000	---
Health Resources			
Health professions student assistance:			
Loans	20,000,000	24,000,000	---
Scholarships	3,500,000	3,500,000	---
Loan repayments	6,000,000	6,000,000	---
D.C. medical manpower assistance	---	9,050,000	---
Manpower initiatives	---	11,189,000	---
Nursing capitation	---	44,000,000	---
Nursing traineeships	---	13,000,000	---
Medical facilities construction	---	74,260,000	---
D.C. medical facilities	---	7,575,000	---

	Revised 1976 Budget	1976 Appropriation	1977 Budget
Elementary and Secondary Education			
Bilingual vocational training	———	2,800,000	———
Drug abuse education	2,000,000	2,000,000	———
Environmental education	———	3,000,000	———
Ellender fellowships	500,000	500,000	———
Ethnic heritage studies	———	1,800,000	———
Impact Aid			
"B" children	136,099,000	341,597,000	———
Savings provision	———	11,000,000	———
Occupational, Vocational and Adult Education			
Vocational education			
Programs for students with special needs	20,000,000	20,000,000	———1/
Consumer and homemaking education	40,994,000	40,994,000	———1/
Work study	9,849,000	9,849,000	———1/
Cooperative education	19,500,000	19,500,000	———1/
Innovation	16,000,000	16,000,000	———1/
Curriculum development	1,000,000	1,000,000	———1/
Higher Education			
Supplemental opportunity grants	———	240,095,000	———
Direct loans	500,000	323,000,000	———
University community services	600,000	12,125,000	———
Aid to land grant colleges	———	9,500,000	———
State post secondary education commissions	250,000	3,500,000	———
Veteran's cost of instruction	28,000	23,750,000	———
College teacher fellowships	1,000,000	1,000,000	———
Public service fellowships	———	4,000,000	———
Mining fellowships	———	3,000,000	———

1/ Authorization for these categorical activities expired at end of FY 1976. These activities can be carried out under the general authority of Basic grants to States (Part B) and Research (Part C).

	Revised 1976 Budget	1976 Appropriation	1977 Budget
Library Resources			
Public libraries	51,749,000	51,749,000	—
College library resources	—	9,975,000	—
Training and demonstrations	—	1,500,000	—
Undergraduate instructional equipment	—	7,500,000	—
Special projects and training			
Elementary and secondary training	5,212,000	5,462,000	—
Vocational training	9,050,000	10,000,000	—
Public Assistance			
Training projects	—	7,450,000	—
Human Development			
Rehabilitation services and facilities innovation and expansion grants	—	18,000,000	—
Aging training	—	*	—

* Not yet considered due to lack of authorizing legislation.

NIH MORALE

Mr. CONTE. Last year I asked Secretary Weinberger about accounts of morale problems at NIH caused by friction between NIH and HEW and OMB. The Secretary felt that this was not so much the case. I am still receiving accounts of this friction and would like to hear your response.

Secretary MATHEWS. I understand that Dr. Frederickson, Director of NIH, has testified that morale at NIH is in good shape and that for the first time in a long time he has or is about to have a full complement of Institute Directors. I am not aware of any friction between NIH, HEW, and OMB other than the normal tension that always exists between various levels of the hierarchy.

HEALTH MANPOWER SHORTAGES

Mr. CONTE. Mr. Secretary, what is your estimate of health manpower needs over the next 5 years or so? How would this be affected by national health insurance, assuming some form is passed?

Secretary MATHEWS. I have some estimates here with me that show that the need for physicians will be in the range of 400,000 to 450,000 by 1980, depending upon such factors as health insurance and so forth. The supply of physicians will be in the same range—435,000 to 450,000 assuming that medical school enrollments are comparable to this year. I would also like to point out that while the supply and demand are expected to be in balance, there could be imbalances in the specialties and in geographic distribution. The new health manpower legislation which we have proposed is designed to alleviate these problems.

A comparable situation also exists for nurses and dentists. By 1980 both the supply and need for nurses is expected to be about 1 million. And for dentists, the need is estimated at around 130,000 with the supply just a few thousand less.

STUDENT LOAN DEFAULTS

Mr. CONTE. Two years ago the default rate for student loans was 5 to 8 percent. Last year it was 18 percent. What is it this year and what steps are being taken to reduce the rate?

Secretary MATHEWS. We are estimating a default rate of about 17 percent, roughly the same as this year.

There are several important steps which we have taken internally as well as seeking new legislation, which Congress has not yet acted on. The legislation we are seeking would eliminate proprietary schools from being lenders—they are our biggest problems; exclude students from declaring bankruptcy as means for avoiding repayment of losses for a period of 5 years after leaving school; and a number of other provisions. We have also published new regulations tightening up on program administration under existing substantive legislative; and we have assigned additional staff to the program, to work on existing default cases. We are also seeking some additional positions in the 1977 budget for the same purpose.

UNCONTROLLABILITY OF BUDGET

Mr. CONTE. Mr. Secretary, in your opening statement you state that about 97 percent is noncontrollable yet you also state that this is not to say that nothing can be done about them. What do you propose we do?

Secretary MATHEWS. The way to change outlays in the noncontrollable program is through legislation. In the 1977 budget the President has proposed a number of ideas which I summarized earlier in my formal statement. What needs to be done now is for Congress to take action by considering the proposals we have requested in this and previous budgets or come up with their own alternatives. Congress to date hasn't seemed willing to consider seriously cost-reducing legislation.

CATASTROPHIC HEALTH INSURANCE

Mr. CONTE. I have been vitally interested in catastrophic health insurance for years. Can you outline the costs of such a program over, say the next 5 years?

Secretary MATHEWS. The cost of such a program vary, of course, with the benefits that are covered. The President's proposal would add about $1 to $1½ billion a year in cost to the medicare program.

BLOCK GRANTS

Mr. CONTE. Many people in my district and I myself have been concerned about the proposal for consolidation of programs into block grants. How much Federal control will be exercised over the use of these grants?

Secretary MATHEWS. The idea is to give the States more flexibility and control over the targeting of the funds. We are trying to minimize Federal control; but we would maintain audit and evaluation responsibilities to make sure the States used the appropriations according to the provisions in the substantive legislation. There also are specific provisions in the proposed legislation which define the population to be served—targeting the funds toward the poor.

Mr. CONTE. Will the States have authority to eliminate presently funded ongoing programs?

Secretary MATHEWS. The proposed authorizing legislation would set up broad categories. Within these categories the States would have the flexibility to target the block grant according to State needs and priorities. A State would not be required to fund all of the individual categorical activities which would be consolidated as long as requirements of the block grant were satisfied.

PHS HOSPITAL BENEFICIARIES

Mr. CONTE. Will the cost of treating the primary beneficiaries of the PHS hospitals elsewhere be significantly lower than the cost of operation of those hospitals which you intend to close such as Boston and New York? What will be the change in cost to the patients?

Secretary Mathews. Ultimately, we would expect the costs to be lower, principally because of the costly repairs and improvements that will have to be made to the PHS hospitals to maintain accreditation standards.

But that is not the basic reason for closing the hospital system. We don't think it is necessary to maintain a federally run hospital system when the local community can provide comparable care. We will continue to reimburse the costs of care for the entitled beneficiaries—principally merchant seamen.

ST. ELIZABETHS TRANSFER

Mr. Conte. When do you forsee transfer of St. Elizabeths Hospital to the District of Columbia government?

Secretary Mathews. We have not set a specific date; but, we are assuming that the process will take several years, considering the time it will take to bring the hospital up to standard.

EDUCATION FOR THE HANDICAPPED

Mr. Conte. Although the request for education for the handicapped provides the same dollar level as for 1976 what will it do to the service qualitatively and quantitatively?

Secretary Mathews. I don't think that can be measured because we provide only a small percentage of the dollars going into handicapped education—the States and local communities put up most of the money.

SSI ERROR RATE

Mr. Conte. What explanation do you have for SSI case error rate of 24.4 percent in 1975?

Secretary Mathews. The current high error rate is caused by several factors. SSI is a new program with many complex eligibility provisions. We are dealing with a large population group which is generally poorer and less well educated than the rest of the population. And the program had to be implemented in too compressed a time schedule. There is also one other factor which should be pointed out. The so-called error rate also reflects what I call discrepancies—a change in an individual's benefit status between the time of the initial determination of eligibility and the audit. These are not real errors even though they are included in the error rate.

We have taken a number of steps to improve the management of the SSI program which we expect will result in a substantial decline in the error rate.

REHABILITATION PROGRAM PARITY

Mr. Conte. What level of funding would be required to maintain the program and service level of the rehabilitative services program as opposed to maintaining the dollar amount?

Secretary Mathews. We are proposing $720 million for the basic grant program, which is the same as 1976 and $40 million more than 1975. We would expect that the State would be able to maintain current service levels with these funds, with the hope that productivity and better management would offset cost increases.

VETERANS PROGRAMS

Mr. CONTE. Why do you feel that it is necessary to terminate the veterans cost of instruction, aid to land grant colleges, and university community services programs?

Secretary MATHEWS. In the veterans program, the Veterans' Administration provides substantial education and other benefits. And we don't see any further need to give colleges money as an inducement to attract veterans to go to school. The money doesn't go for the veterans.

In the university community services program, the original idea was to encourage university faculty and staff to work with the local communities in the solution of their problems. It was a good idea but the program simply hasn't worked as conceived. The land grant program is about 100 years old and was initiated to help foster the development of new higher education institutions. It has achieved its purposes.

FINANCIAL PROBLEM OF PRIVATE COLLEGES

Mr. CONTE. It is clear that smaller, private colleges are feeling the economic crunch very badly, to the extent that many are on the brink of financial collapse, what do you propose to do in their behalf? What programs do you think are most beneficial in this area?

Secretary MATHEWS. Many of our programs help smaller, private colleges, for example, all the student assistance programs. In fact, I can't think of any Federal programs in higher education for which private schools are ineligible. However, as I said earlier, the word I get from the private schools is that a reduction in regulatory requirements would be at least as welcome as more funds.

Mr. CONTE. More specifically, would you expound on your views toward the various loan programs available to institutions and their students, with the obvious biases toward the public or private institution depending on the type of grant you are dealing with?

Secretary MATHEWS. As far as I know there is no built-in bias in the administration of the student aid program—grant or loan. The real difference is the cost differential between the publics and privates. A student can probably pay for more of his education with student aid at a public institution than he can at a private one because the costs are generally lower at public colleges and universities. That is where the bias comes in.

VETERANS

Mr. CONTE. What are your views in regard to Veteran's education benefits? What are your plans in this regard for the coming year?

Secretary MATHEWS. I believe Federal support should go directly to the student, and I think this is adequately taken care of under the GI bill. Our budget for 1977 does not recommend funding for the veterans' cost of instruction program, and I urge Congress to adopt the recommendation. If there was a need for that program of rather insignificant support to institutions during and immediately after the Vietnam war, the need is now passed, and any benefits targeted toward veterans are appropriately associated with the programs of the Veterans' Administration.

VOCATIONAL EDUCATION

Mr. CONTE. Now to the area of vocational education, would you please give us your overall view of where the emphasis should be placed in this area?

Secretary MATHEWS. Vocational education should be closely tied to the job market and seek to provide training in marketable skills. Furthermore, I think it is important to provide opportunities for adults as well as youth.

WORK STUDY

Mr. CONTE. What about work study and the like, do you favor increased utilization of such educational programs.

Secretary MATHEWS. Yes; I think work study, for example, is a good idea and I would favor its continuation. But that doesn't have to mean that the Federal Government has to increase its subsidies. The private sector already provides something like $5 billion worth of support. I see no reason why more couldn't be done in that area.

CAREER EDUCATION

Mr. CONTE. What sort of coordination is going on between your office and Labor in regard to career education and the general unemployment situation?

Secretary MATHEWS. We are working with Labor. I met with former Secretary Dunlop on the coordination of all our programs and we expect to continue with Secretary Usery. On career education, the Office of Education and the National Institute of Education are working together with the Labor and Commerce Departments to coordinate career education objectives and programs.

NIE

Mr. CONTE. Would you describe briefly your impressions of the National Institute of Education; the progress made in the administration of this relatively new agency?

Secretary MATHEWS. I strongly believe NIE is now on its feet, and it's time to get on with the obviously important job of gaining and disseminating knowledge about education. In my view the amount spent on educational research should be in as close proportion to the educational dollar as is medical research to health. The early problems of NIE—the establishment of the council, some carryover of possibly mediocre research efforts—are behind us, and I hope the controversy with the Congress is over too.

"BACK TO BASICS"

Mr. CONTE. There has been much talk concerning the need for "back to basics" education, because many people are being churned out of educational institutions that apparently can't read; would you tell us about how valid these observations are, what is being done about it, and what you would like to see being done?

Secretary MATHEWS. I would suspect that if you examined what is being taught today, you would still find that the emphasis is on basics.

And yet we do need to do a better job with the 3R's, not only do the schools need to be invested in that issue, but so does the community and the family. They too are powerful forces.

LABOR RELATIONS

Mr. **Conte.** Labor relations is being an increasingly more important area of concern for administrators like yourself especially in the health and education fields; would you please detail for this committee your concerns in these areas, especially concerning the growth of teacher unions?

Secretary **Mathews.** That is principally something which the States and local jurisdictions are involved in. Our responsibilities do not extend into that area. I am hesitant to comment on it, particularly since my own background is as a college administrator, and your reference, I assume, applies more particularly to elementary and secondary education.

FOLLOWTHROUGH

Mr. **Conte.** What is your impression of followthrough and its continued existence?

Secretary **Mathews.** My understanding is that successive administrations have recommended the phasing out of this program by not starting new classes. The reasons are that enough experiments have been tried that nothing more needs to be demonstrated at the Federal level. It's obviously too small a program to be a service program. Title I funds are available wherein the States and local jurisdictions can continue or start programs if they wish. I see no reason to disagree with the budget proposals.

TEACHER CORPS

Mr. **Conte.** The Teacher Corps—what is being done here, and how do you feel about the progress it has made in disadvantaged settings?

Secretary **Mathews.** We are proposing about $38 million in the 1977 budget for that program, the same as in previous years. I have only a limited knowledge of how successful the program has been; but, I believe it has been helpful. When you have hearings on the program later on they could give you more specific information.

INSTITUTIONALIZATION OF THE HANDICAPPED

Mr. **Conte.** How do you feel toward the institutionalization of handicapped individuals and what alternative to institutionalization do you favor?

Secretary **Mathews.** My personal view is that institutionalization should be avoided wherever possible And there are things that can be and are being done. In HEW, for example, the community mental health centers program has already demonstrated a successful alternative to institutionalization. Vocational rehabilitation provides assistance. In education, the design of special handicapped programs in the public schools so that handicapped children can participate along with the other children is another positive step. Eliminating job discrimination practices against handicapped people and eliminating architectural barriers which affect the mobility of physically handicapped individuals are other important actions. And educational efforts to improve the public's understanding of the problems of the handicapped are important.

INCREASED EDUCATION PROGRAMS

Mr. CONTE. In what areas of education do you favor increased spending by the States as opposed to the Federal Government?

Secretary MATHEWS. My view generally is that the Federal Government should target its dollars on building capacity, demonstrating new methods and techniques, and assisting in attaining equity in student opportunity. The States should finance services. This may best be exemplified by the new Education for all the Handicapped Act. Some people feel the Federal Government should pay for all incremental costs of educating the handicapped. I think that is a State and local responsibility.

BUSING

Mr. CONTE. Could we have your views on court-ordered busing, and more generally on the topic of busing to achieve racial balance?

Secretary MATHEWS. It is my view that the question of busing has to be judged on the basis of its effectiveness. And if it isn't effective then other means should be tried. There are examples where schools have been able to achieve desegregation and provide quality education without it.

EDUCATION EMPHASIS

Mr. CONTE. What areas in the whole educational field do you feel have been most overlooked, and merit much greater concern?

Secretary MATHEWS. I have written at length on several problems that are "neglected". One is the need for a more comprehensive view of education—to include all educational forces, not just schools. Another is the need to get the community and family reinvested in the public schools. Still another is the current danger of training all our educators into bureaucrats with an excess of forms and formulas. And then there are the larger issues before society that higher education in particular needs to focus upon.

QUALITY OF HIGH SCHOOL EDUCATION

Mr. CONTE. What suggestions do you have in regard to the condition and quality of the education or lack of it presently being offered in the Nation's high schools? What programs are you thinking about in this area?

Secreatry MATHEWS. That is a complex subject, as you can appreciate. And I think a good deal of the discussion of the quality of our secondary education has been generated by criticism from the higher educational community that incoming students are not as well prepared as those in the previous generation. When you analyze this, you realize that the composition of your student population is different than it used to be. Higher educational opportunities have been significantly expanded for individuals from disadvantaged backgrounds. And I think it would be fair to say that the quality of education provided to many disadvantaged children has not been as good as that provided to students who have traditionally made up college student enrollments. There is another factor, too, which I think contributes to the discussion of quality. The complexity of jobs has been increasing, and it is my view that our educational programs, especially at the secondary level have not kept pace with the demands of the job market. The issue is what do you do about this. The most important thing in my view is the recognition that there are disparities in the education offered our children. And changes are being made. Special funding by the Federal Government to improve educational programs for disadvantaged children—title I, ESEA.

Head Start and emergency school aid—are examples. Another is improved and expanded research in order to more closely relate education to what the student will be facing when he or she leaves school. These are the things that will make a difference.

HANDICAPPED EDUCATION

Mr. CONTE. Do you favor increased Federal expenditures to handicapped individuals, or do you regard the present programs adequate here?

Secretary MATHEWS. No; as I indicated, we have asked for increased funds to build capacity and demonstrate new methods. We think the States should bear the added costs of teaching and training handicapped individuals.

TRANSITION QUARTER

Mr. SHRIVER. Mr. Secretary, before addressing the 1977 requests, I wonder if you would comment on any potential problems for programs under your jurisdiction during the transition quarter. This committee has requested such information by letter, but perhaps you could tell us if such programs as adult education might have any problem? I ask this because there are people in my district and in our State department of education who cannot plan their programs effectively until they know for sure that the transition quarter is taken care of.

Secretary MATHEWS. There should not be any problems with programs like adult education or the other elementary and secondary State grant activities which are on an advance appropriation basis. It is my understanding that funds for the 1976–77 school year have already been appropriated and will be awarded to the States during the transition quarter. They will get all their 1976–77 money then.

IMPACT AID

Mr. **Shriver.** You are again going through the motions in regard to impact aid. While you are calling for a "reform" of this program, it appears that the changes in the program already voted by Congress are largely ignored. Would you tell us what changes have been made in the administration of this program since Congress acted? I would like you to specifically address what has taken place or will take place in the Washington, D.C. suburbs, where this program was abused in the past.

Secretary **Mathews.** We are not ignoring the new provisions of the impact aid legislation. We are asking Congress, both through special appropriation language and substantive legislation, to change certain provisions. Essentially our 1977 proposal would fund "A" children and special provisions according to the legislation; and we are asking for repeal of funding for the low rent public housing provision and "B" children.

With respect to the suburbs of Washington, the new law improves the situation by no longer counting as "B" parents those who live outside the district but work in it. However, the law also contains a hold harmless provision which prevents a school district which had a significant number of "B" children from losing more than 10 percent of its Federal payments each year through fiscal year 1978.

NCI CUTBACKS

Mr. **Shriver.** One of the items here on which we will get much mail is the proposed cutback of nearly $56 million from the amount we appropriated for 1976 for the National Cancer Institute. Instead, you want increases for education research and medical peer review. These latter items may be important, but I doubt that most Americans will agree with your priorities. What will be the effect of the cutback in cancer research? Be as specific as you can.

Secretary **Mathews.** The cancer budget would maintain the program at roughly $690 million, the same as 1975. We believe that this represents a considerable investment which will sustain a high quality research program. Also, it should be noted that basic research in the other NIH institutes has an important relationship to cancer research and contributes greatly to it.

With respect to education research, I would make the point that we spend a fraction of the amount on education that we spend on medical research. Furthermore, if we are able to mount an effective medical peer review system, it could prove to be the most effective device we have for cutting medical costs—and that objective is at the very top of our priority list.

MEDICARE CHANGES

Mr. **Shriver.** The administration is proposing to tie the medicare insurance deductibles to adjustments in social security cash payments. These social security benefits are now pretty much tied by law to increases in the cost of living, and they are designed to help these people cope with the increased cost of living. Are you proposing that whenever they get a cost-of-living increase, their deductible for medical care will go up?

Secretary MATHEWS. Yes: that is correct. We are proposing that an individual's supplementary medical insurance deductible change as his benefits change.

DIRECT STUDENT LOANS

Mr. SHRIVER. Again you are proposing to terminate the direct student loan program. Would you tell us your objections to this popular program. The repayment rate on this program has been pretty good, has it not—at least it is better than the guaranteed loan program. If we funded this direct loan program for a few more years, would it become largely self-supporting through repayments? How long would that take and how much money would be needed?

Secretary MATHEWS. Our proposal would not affect the schools' loan funds. We are only proposing to discontinue further capitalization of the funds. In 18 years, the Federal Government has provided $3.2 billion to the schools. We believe that is enough.

With that level of funding the schools should be able to sustain the revolving funds. And, in fact, I believe that $252 million will be awarded out of the funds for new loans this year. And as the schools collect from past loans, they will have even more funds to relend.

Furthermore, we propose supporting the guaranteed student loan program at a level which annually produce $1.3 billion worth of loans.

EDUCATION CUTS

Mr. SHRIVER. When you remove the forward funding request for vocational education, the request for the Education Division is actually lower in 1977 than 1976, is that correct? At least in terms of budget authority.

Secretary MATHEWS. Yes, it is. We are asking for about $6.1 billion, excluding the amount to put Vocational Education on a forward funded basis. That compares with $7.5 billion Congress appropriated for 1976.

EDUCATION BLOC GRANTS

Mr. SHRIVER. Explain further the added flexibility you say State and local governments will have in administering the consolidated education program if Congress accepts your proposals.

Secretary MATHEWS. The proposal would consolidate something like 24 different education grants into one grant. The flexibility comes with the elimination of all the separate programs. Under the new grant, the State will be able to decide the best way to target the money according to the conditions that exist in that State. However, 75 percent of the funds must be spent for programs to benefit the disadvantaged and handicapped.

GRANTS TO THE DISADVANTAGED

Mr. SHRIVER. While you say this education program consolidation focuses more money on disadvantaged and handicapped, in actuality the grants for disadvantaged would go down $150 million in 1977, the number of children benefitted would be down and the average expenditure per pupil would go down, according to the data in your budget summary we got early this year. Would you comment on that?

Secretary **Mathews**. Under the bloc grant, the total amount that will be requested is roughly the same as what Congress appropriated in 1976—there is about $260 million more associated with the bloc grant than the funds requested under current law which are before the committee. The reduction you mentioned in title I under current law would be offset by added funds in the bloc grant proposal. Furthermore, the States would have to program at least 75 percent of the bloc grant total for programs to benefit the disadvantaged and handicapped.

Mr. **Shriver**. Your consolidation of education programs leaves nothing for public libraries, college libraries, or undergraduate instructional equipment. That's a lot of assistance you are cutting out all at once. What is the justification for that?

Secretary **Mathews**. We are not proposing funding for those programs under current law. However, in the bloc grant proposal, the States could spend some of their allocation for those activities.

[**Note**.—Subsequent to this hearing it was announced that the proposed education bloc grant would not include in the consolidation the above mentioned library programs.]

B.E.O.G.'S

Mr. **Shriver**. Your fiscal 1977 request for the basic educational opportunity grant program is based on a 60 percent participation rate, is it not? Yet we had a hearing yesterday for $180 million in supplemental funds for 1976 because the participation rate is now about 74 percent. Based on 74 percent, what would you need for 1977 for this program.

Secretary **Mathews**. For the 1976–77 school year, we would need about $600 million more in the 1976 appropriation; for the 1977–78 school year we would need about $280 million added to the 1977 request.

GOBBLEDYGOOK

Mr. **Flood**. Almost every issue of the Federal Register includes some new or revised regulations on HEW programs. Most of them are in English more or less—but they are not exactly models of clarity. Are you doing anything to simplify and clarify all of these rules and regulations?

Secretary **Mathews**. That is a difficult problem as you can appreciate. The writing of regulations is complicated by many factors, including the way Congress writes the law, which sometimes adds to their complexity. We expect that the whole process will improve, though, as we recently set up a new office for regulatory review to work on getting regulations out on time, to make sure their provisions reflect congressional intent and to improve their quality.

MAXIMUM ALLOWABLE COSTS

Mr. FLOOD. What additional costs do you have budgeted to implement the MAC program, including the cost of necessary support programs? Where are these additional costs detailed in the budget, and what is the total dollar amount?

Secretary MATHEWS. We have estimated an HEW cost of about $2.1 million and State costs of about $3.5 million for initial implementation of the program. We would expect future costs to drop though. The HEW costs are budgeted in SRS, SSA, and in the Public Health Service. Offsetting these costs though, are the savings we estimate—$60 to $75 million per year—which both the States and the Federal government will realize.

Mr. FLOOD. The maximum allowable cost program rests, in large part, upon the premise that all drug products subject to MAC are interchangeable. What facts do you have to substantiate this premise? Further, it is my understanding that the bioavailability regulations, setting standards for specific drugs, are still in the proposal stage. Logic would suggest that these standards should be in place before the MAC regulations are implemented. You seem to be proceeding in the opposite direction. Aren't you putting the cart before the horse, and, if so, why?

Secretary MATHEWS. The regulations set up a frame work for implementing a maximum cost reimbursement policy based upon generic equivalence. Work is still going on to establish which drugs we would pay a maximum allowable cost based upon that principle. No MAC limit would be set though until FDA has studied the drug and determined that there are no industrywide quality or bioequivalency problems.

BILINGUAL EDUCATION

Mr. ROYBAL. The Supreme Court has ruled that school districts which have a substantial number of non-English speaking students must provide bilingual education opportunities. Under these circumstances, how can you justify the proposed cut of $8 million in bilingual education? How many students are being served by the program in fiscal year 1976? How many would be served in fiscal year 1977 if we cut the program by $8 million?

Secretary MATHEWS. When the budget was prepared, there was a $10 million increase over the revised 1976 estimate; but, the proposed 1976 rescission was not accepted by the Congress. Regarding the number of children served, I don't have the figures with me; but I believe they are included in our budget justifications which you have. I want to assure you, however, that we attach a high priority to this program.

SEOG'S

Mr. ROYBAL. You are trying to phase out SEOG's because you contend that they duplicate the basic opportunity grant program (BEOG). What are the qualifications for an SEOG? Could a student fail to qualify for a BEOG yet qualify for an SEOG?

Secretary MATHEWS. A student who is receiving aid from a higher educational institution— either from our campus based progams like work study or the school's own student aid funds—and is in exceptional financial need is eligible for a supplemental grant. A student could in fact receive both a basic and supplemental grant or he could receive either one and be denied the other. The reason for this is that it is up to the school to determine whether the student has exceptional financial need for a supplemental grant. There are no definitions of need in the law—the school could make eligibility judgments case by case. The basic grant program on the other hand has national standards of need.

WORK STUDY

Mr. ROYBAL. The budget proposes a cut in the work study program. Why? Also at present, the Federal government pays 80 percent of the cost of the program, with a 20 percent match by the college. The budget proposes to raise the college match by 10 percent per year for three years. Won't this put a great strain on the schools involved?

Secretary MATHEWS. Work study is a popular program. But, because of the very large support for it in the private sector—roughly $5 billion worth—we believe that we can reduce the special Federal subsidy without significantly affecting the total program. Regarding the proposed change in matching, I am sure that you know that what the Federal program does is to pay 80 percent of the salary costs of the student's jobs, principally with the school. The school is getting the advantage of the student's work but now is required to pay for only 20 percent of the costs. If the school filled the job with other than a work study student, they would have to pay 100 percent of the costs. We think that the schools should assume an equal partnership with the Federal government in this program.

NHI CUTS

Mr. ROYBAL. Why are you proposing cuts in funding for the Cancer and Heart Institutes?

Secretary MATHEWS. When the budget was developed, the 1976 appropriation for those programs had been vetoed and at that time, they were not reductions. It wasn't until after the budget was transmitted to the Congress that the vote on veto override was taken. While 1977 is lower than 1976 now, it is important to point out that the amount of funding for those two institutes is still significant—$690 million for cancer and $340 million for heart. That is more than $1 billion for the two combined—enough I think to take advantage of any research breakthrough.

HEALTH BLOCK GRANT

Mr. ROYBAL. I note that you want to do away with categorical health programs and substitute block grants. However, when you analyze the block grant request, the overall funding for programs other than medicaid is being cut. Why are you cutting these programs?

Secretary **MATHEWS**. Again, the dollar level in 1977 was based upon continuing proposed 1976 funding levels for programs other than medicaid. But, overall, the $10 billion total for the block grant is greater than the 1976 level.

MEDICARE COST SHARING

Mr. **ROYBAL**. Since people on social security are already squeezed by inflation how can you expect them to pay a larger share of their initial hospital and physician costs?

Secretary **MATHEWS**. We are asking for greater cost sharing but we are also asking Congress to enact other provisions to protect against the financial disaster that can occur with severe illness. And we would also note that the elderly poor who are eligible for medicaid can get reimbursement from that program for costs medicare doesn't pay.

Mr. **FLOOD**. Thank you, Mr. Secretary.

Secretary **MATHEWS**. Thank you, Mr. Chairman.

Mr. **FLOOD**. We will put in the record a number of special reports.

[The reports follow:]

SPECIAL REPORTS

TABLE OF CONTENTS

	Page
Alcoholism	234
American Indians	291
Cerebral Palsy	324
Day Care	334
Drug Abuse	348
Family Planning	369
Hearing and Speech	424
Juvenile Delinquency	480
Mental Retardation	500
Migrants	563
Multiple Sclerosis	575
Muscular Dystrophy	586
Nursing Homes	599
Older Americans	616

Obligations for Program in Alcoholism
(In Thousands of Dollars)

	1973	1974	1975	1976 Appropriation	1977 Estimate
Public Health Services:					
Alcohol, Drug Abuse, and Mental Health Administration					
National Institute on Alcohol Abuse and Alcoholism					
Budget Authority......	76,314	137,947	146,091	138,923 2/	98,062
Obligations...........	(156,637)	(199,975)	(167,569)	(138,923) 2/	(98,062)
Health Services Administration					
Indian Health Service...............	1/	1/	1/	1/	
National Institutes of Health					
National Institute of Arthritis, Metabolism, and Digestive Diseases	1/	1/	1/	1/	
Subtotal, PHS					
Budget Authority......	76,314	137,947	146,091	138,923	98,062
Obligations...........	(156,637)	(199,975)	(167,569)	(138,923)	(98,062)
Office of Human Development:					
Rehabilitation Services Administration:					
Basic State Grants....	29,450	26,650	30,600	29,920	30,240
Expansion Grants......	360	286	---	---	---
Facility Improvement..	51	34	35	28	26
Research and Demonstrations	300	---	---	---	---
Rehabilitation Training	48	---	---	---	---
Special Foreign Currency Program..............	100	---	---	---	---
Subtotal.........	30,309	26,970	30,635	29,948	30,266
Public Services Administration:					
Services to Alcholics...	---	26,500 3/	35,326	40,600	43,200
Total............	106,623	191,417	212,052	209,471	171,528

1/ Obligations not identifiable

2/ The 1976 column shows no funds for Indian Programs, although actual awards will be made by NIAAA in 1976. This was done to put the budgets for both years on a comparable basis.

3/ This amount, the same as reported in the 1976 Hearings is a preliminary actual Actual dollars amounted to $33,476,000, (Source: 1974 OA-41.7 (c) reports) and were projected into 1975-1977.

of the nation's work force are alcoholic individuals, while almost another 5 percent are serious alcohol abusers. Although the most visible victims of alcoholism are inhabitants of skid rows across the nation, they represent only 3 to 5 percent of the alcoholic population. Public intoxication, however, usually involving skid row inhabitants, accounts for 50 percent or over one million of all arrests reported annually, including arrests for traffic violations.

Among American Indians, alcoholism is at an epidemic level. The rate is at least 10 percent, or twice as high as the national average. On some American Indian reservations the rate runs from 25 to 50 percent. At the present time, the Institute awarded 148 programs for Indian people in response to applications originated by Indians for programs run by Indians representing an investment of $16.6 million for FY 1975.

Alcohol abuse and alcoholism are recognized as major health problems in most developed and many developing nations, but despite the virtual universality of the problems, there has been very little multinational collaboration in developing more effective methods to combat them.

Alcohol problems viewed from any perspective cause grievous pain: hurt to the afflicted person, his family, and society. As an illness, alcoholism is devastating; the source of accidents and poor health; a contributor to the disruption of families as well of human misery.

PUBLIC HEALTH SERVICE
Alcohol Drug Abuse, and Mental Health Administration
National Institute on Alcohol Abuse and Alcoholism

Among the many interesting developments in the field of alcoholism during the past 5 years, perhaps the most significant event has been the wide-ranging commitment of the Federal government to the problems of alcohol abuse and alcoholism.

The National Institute on Alcohol Abuse and Alcoholism, created by an Act of the United States Congress (Public Law 91-616), was formally established in May 1971. The Institute develops and supports programs to (1) improve treatment services for alcoholic persons in States and communities, (2) treat and rehabilitate employees with drinking problems in Government and private industry, (3) modify public attitudes toward alcoholism and alcohol-related problems by developing a program of education and public information, (4) train professional and non-professional personnel, and (5) determine through research the causes and prevention of alcoholism and alcohol abuse. The Institute is rapidly developing a coordinated national alcoholism program. As a step toward the accomplishment of this goal, the National Institute on Alcohol Abuse and Alcoholism is providing funds for the development of adequate treatment services for alcoholic persons, based, whenever possible, on existing services.

Fiscal year 1972 was the Institute's first full year of operations, a year of dynamic growth and challenge. Throughout the country, along with the expansion of programs initiated in FY 1971, new programs for alcoholic people were developed such as those for public inebriates and the alcoholism poverty program.

During FY 1973 the Institute moved substantially closer to its primary goal of making effective treatment available at the local level to every alcoholic person in the United States. The development of alternative fiscal resources was also stimulated in order to expand services and make projects more financially independent. Further, recognizing that no illness has ever been eradicated by just treating the casualties, the Institute made a sound beginning towards the long-range goal of prevention. Sophisticated educational and informational techniques were initiated to foster the concept of responsible alcohol use among those who choose to drink.

During FY 1974, the Institute continued to foster the development of community-based resources for alcoholism treatment. The alcoholism field in general continued its significant growth at State and local levels in response to the awareness and mementum generated by the Federal leadership. The NIAAA leadership role was enhanced by its placement as a separate Institute within the new Alcohol, Drug Abuse, and Mental Health Administration. In FY 74, the Institute also began more intensive enlistment of the Nation's private enterprise system to the national alcoholism effort. NIAAA initiated programs to foster the development of guidelines for counselor certification and alcoholism program accreditation as an important step towards generated greater third-party payments for treatment services. An increasing number of private companies initiated occupational alcoholism programs for their employees. In the prevention area, the NIAAA's National Center for Alcohol Education began operations, and the need to respond to increasing public awareness sparked a significant expansion in the activities of the National Clearinghouse for Alcohol Information. Near the end of the Fiscal Year, the program authorities of the NIAAA were renewed and expanded by the passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (P.L. 93-282).

During FY 1975, the Institute began to make inroads with accreditation of alcoholism programs under newly adopted national standards to provide more effective treatment through patient fees, health insurance, and other third-party sources. Federal alcoholism efforts began to include the basic provisions, where necessary, for financial support, clothing, shelter, health care, legal assistance, and vocational training.

Occupational alcoholism programs were greatly expanded in 1975. More than 275 new occupational programs were established independent of NIAAA funding throughout the nation to currently serve a work force of nearly 2,750,000 people established by employers in the private and public sector for the benefit of the employees suffering from alcohol abuse and alcoholism. Significant partnerships also have been developed with the Civil Service Commission and the Department of Defense to foster Congressionally mandated occupational programs for Federal employees and servicemen with alcohol-related problems.

One of the major activities conducted by the Institute in 1975 was a National Alcohol-Health Promotion Conference which brought together scores of medical professionals, corporation executives, college educators, labor and management leaders and key individuals from the country's voluntary organizations.

The number of research grant applications reviewed during FY 1975 was 263, and this represents a 289% increase in applications received over FY 1971. This growth in research grant applications reflects an increasing awareness on the part of researchers of the importance of alcoholism as a public health problem.

The Federal resources administered by the NIAAA reaches States, communities, and individuals through the activities of four operating Divisions: Resource Development, Special Treatment and Rehabilitation Programs, Prevention, and Research.

DIVISION OF RESOURCE DEVELOPMENT

The Division of Resource Development became operational during FY 75 and was officially created in early FY 76.

The Division of Resource Development (1) plans and administers programs for the support of nationwide services for the prevention of alcoholism and the treatment and rehabilitation of alcoholics, under the alcohol formula grants to States program, which supports State efforts in planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism; (2) develops the policy and regulatory framework for comprehensive State plans for the establishment and delivery of alcoholism services, and reviews and approves individual plans; (3) collaborates with, provides assistance to, and encourages national, State, and local governments, hospitals, and voluntary groups to facilitate and extend programs for the care, treatment, and rehabilitation of alcoholics; (4) develop broad programs of training in the field of alcoholism; (5) develops and administers special projects designed to increase third-party payments for alcoholism treatment and rehabilitation services; and (6) administers the program of special grants to States to implement the provisions of the Uniform Alcoholism and Intoxication Treatment Act.

Training Branch

The extramural training program is an integral part of the total NIAAA program for dealing with problems of alcohol abuse and alcoholism. It is intended to make available better services and research by increasing the knowledge and improving the skills and techniques of persons already in the alcohol field and of professionals and paraprofessionals intending to enter the fields of alcohol-related service and research.

During Fiscal Year 1975, closer coordination with the National Institute on Drug Abuse was initiated, and a staff member was recruited with a principal responsibility in this area.

Under the aegis of the National Research Service Awards Act, the Branch initiated support of four institutional research training grants and 20 individual research fellowships. These grants provided both pre- and postdoctoral support. It is hoped that these awards will lead to more and better research in needed areas of new knowledge about alcohol and alcoholism.

Of particular significance are continued efforts to initiate and support training to deal with alcohol problems among minority groups. In addition to other minority training programs, a significant number of new American Indian training programs have been initiated.

The Institute funded 104 training grants and contracts for $10,114,000, and 20 fellowships for $244,000. Of the 104 grants and contracts, 61 were new, 19 were competing renewals, and 24 were continuations. Sixteen supplemental awards were also made. In addition the National Center for Alcohol Education received funding of $1,062,000 for a new contract from the Training Branch; additionally, a modification to the previous year's contract provided NCAE with $736,000 from other budget activities.

Career Teacher Program

The goal of the Academic Career Teacher Award, funded jointly since 1972 by the National Institute on Drug Abuse (NIDA) and the NIAAA, is to provide support to every Medical School and School of Public Health in the United States to improve the education of their students in the area of alcohol and drug abuse. The grant provides for the advanced training of a faculty member nominated by the sponsoring institution. During the two to three year Award period, the institution is required to release the Career Teacher from activities not directly related to his/her development as an academician and teacher and to provide opportunity for impact on the curriculum of the school.

To date, 37 Career Teachers have been funded: 20 by NIDA ($800,000 annual cost); 17 by NIAAA ($680,000 annual cost). Additionally, NIDA has provided funds at a cumulative cost of $700,000 to Baylor University Medical School and the Downstate Medical Center to serve as focal points for resource development, evaluation, and coordination of Career Teacher activities. Five conferences have been sponsored.

Two significant outcomes of the Career Teacher Program are: (1) Development through the personally designed training programs of the Career Teachers of a creative, knowledgeable body of professionals deeply concerned about and committed to alcohol and drug education for undergraduates and residents and to continuing education for the practitioner. (2) The development of curricula reflecting issues in the addictions within Medical Schools and Schools of Public Health, tailored to the needs of each school.

Career Teachers who have completed or are about to complete their terms of support are developing guidelines for the formation of a professional association to further medical education in the addictive disorders.

Area Alcohol Education and Training Programs

Four Area Alcohol Education and Training Programs (AAETPs), covering all the States and territories, were established to enrich and expand areawide, State, and local planning and educational efforts in response to local needs. The first phase of their program was to conduct and analyze an extensive area needs assessment. The second phase was to set program priorities according to the assessed needs, and the third to establish a sophisticated, long-range approach to meeting education and training needs in future years.

Overall, the needs assessment showed a need for additional training of existing personnel as the highest priority. Counselors in the alcoholism field indicated a need for training in counseling techniques and the assessment of clients for individualized treatment plans rather than for more knowledge about alcoholism. Community education programs were rated as highly desirable by all four AAETPs; in particular, there was a concern for programs involving youth. Training and education for personnel working with minority groups was also indicated as a high priority. The AAETPs have used the results of their initial needs assessments to determine priorities for the allocation of their grant funds and to set future programmatic goals.

In FY 1975, the AAETPs awarded 68 subgrants and 93 individual stipend awards, from which an estimated 10,000 people will receive some form of short or long-term training. The awards totaled $1,365,639 for subgrants and $246,614 for individual stipends.

National Center for Alcohol Education (NCAE)

The NIAAA established the National Center for Alcohol Education (NCAE) in June of 1973. NIAAA formed the Center through a contractual agreement with the University Research Corporation (URC), a private consulting firm that has specialized in human service programs throughout its ten-year history. NIAAA mandated the Center to research, design, and develop quality training and education programs for people who are striving to increase the supply and improve the skills of alcohol abuse prevention and treatment workers. The Center also plays a role in the growth and development of an education and training network through its direct assistance to Area Alcohol Education and Training Programs and university summer schools for alcohol studies. In FY 1975, the NCAE was funded by NIAAA in the amount of $1,798,000, $1,062,000 from the Training Branch, and $736,000 for a modification to the previous year's contract from other budget activities.

Located in Arlington, Virginia, the Center draws on a staff of 21 persons. It also draws heavily upon the solicited advice of consultants (experts and test groups of consumers) and NIAAA's Project and Contract Officers.

The Center's education and training activities comprise two major task areas designed by the current contract between NIAAA and URC: Experimental Education Laboratory and Curriculum Development.

The Experimental Education Laboratory has completed three courses that address critical training needs among alcohol workers: management skills; creating community-wide systems for helping alcoholic people; and strengthening the capabilities of field workers to design and deliver training. The Center has also completed a training program for NIAAA's 28 recently appointed Prevention Coordinators for the Nation's States and territories.

The Curriculum Development unit has completed development of a curriculum called Decisions and Drinking, keyed for women. This presents basic information about the use of alcohol and provides a context in which people may examine their own attitudes about drinking, consider their own personal practices, and consciously choose among the sensible options available.

State Assistance Branch

The mission of the State Assistance Branch is the development of a more comprehensive network of services throughout the State in order to provide more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism. This effort is undertaken by awarding funds on a formula basis to the designated single State Agency in each State responsible for the development and implementation of the State Alcoholism Plan. These funds, made available after approval of the plan, are to assist the State in planning, establishing, maintaining, coordinating, and evaluating alcoholism programs.

During Fiscal Year 1975, a total of $52 million was awarded to the 50 States, District of Columbia, Puerto Rico, Guam, Virgin Islands, Trust Territory of the Pacific Islands, and American Samoa on the basis of an approved update of the State plan.

During Fiscal Year 1975, the Branch initiated the Special Grants for Implementation of the Uniform Alcoholism and Intoxication Treatment Act as authorized by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974, P.L. 93-282. The Special Grants are to assist States which have adopted the basic provisions of the Uniform Act in their efforts to approach alcohol abuse and alcoholism from a community care standpoint. The basic provisions include decriminalization of public drunkenness by the State and each of its political subdivisions, and requirements regarding acceptance of individuals into treatment and involuntary commitment. An eligible State may receive up to $100,000 plus an amount equal to 10% of its formula grant allotment for the Fiscal Year during which application is made. Sixteen Special Grants were awarded in Fiscal Year 1975. The total amount awarded was $2,679,163. It is anticipated that an additional seven States will qualify for a Special Grant in Fiscal Year 1976.

The Branch contracted with the International Association of Chiefs of Police to develop a training package for police and police academies. The package will include a training manual and an instructor's guide. The training program will focus upon the role and responsibility of police in implementing Uniform Alcoholism legislation. The manuals are scheduled for completion during Fiscal Year 1976. Following field testing of the package, the manuals will be refined and then widely distributed.

A State Alcoholism Program Information System is presently being developed to supply information regarding State alcoholism programs, including information relating to the formula grants to the NIAAA and to the State Agencies. The Information System is to be initiated early in Fiscal Year 1976.

DIVISION OF SPECIAL TREATMENT AND REHABILITATION PROGRAMS

The Division of Special Treatment and Rehabilitation Programs developed and supported programs designed to reduce and prevent alcohol-related problems, with emphasis on the needs of special population groups. Programs provide treatment services for alcoholic employees of government and industry, cross-populations, low-income persons, American Indians, Alaskan Natives, Blacks, Spanish-Americans, the criminal justice population, women, youth, migrant farm laborers, chronic drunkenness offenders, drinking drivers, aged people, Joint Alcohol and Drug Abuse Clients and non-categorical programs. In some cases, funds are provided for staff only.

The Division launched, under contract, a National Technical Assistance and Monitoring Program that provided an on-site review of approximately 375 NIAAA-funded service programs. The program was established with the objectives of identifying the strengths and weaknesses of the individual projects, assessing their progress toward self-support, and providing the Institute with an up-to-date evaluation to be utilized in considering continuation funding requests. In addition, the contract has provided limited program and management technical assistance to projects in areas requiring further strengthening.

The technical assistance and monitoring program builds on the management program for service projects conducted by the Division under contract. The management program implemented a system based on the two cost accounting manuals produced in FY 1974--one for large-scale programs and one for small service projects. This system is currently in use across the country. In addition, the contractor provided 300 man days of management technical assistance during FY 75 to selected projects in an effort to upgrade their management effectiveness.

As part of the Institute's effort in Health Insurance, this Division provided consultation to the Health Insurance Association of America (HIAA) in the development of a proposal that seeks to demonstrate the feasibility of providing broad-based benefit coverage for alcoholism in health insurance policies written by commercial carriers. It is anticipated that the data generated from this proposed demonstration will provide member insurance companies of HIAA with the necessary knowledge to offer effective and expanded alcoholism treatment benefits, and will add to the Institute's knowledge regarding the conditions necessary for implementing such benefits within the commercial carrier industry. In a companion effort, consultation was provided to the Blue Cross Association of Chicago, Illinois, in the development of a planning survey proposal to analyze and assess the implications and feasibility of installing a broad-based benefit package for alcoholism within the nation's Blue Cross Plans that currently enroll approximately 87.5 million subscribers. Both of these health insurance initiatives are seen by the Institute as aiding in removing financial deterrents to care and as providing an essential base for third-party reimbursements that will stimulate the continued growth of local service providers.

The Division has been concerned about the need for upgrading the community organization skills of staff working in local service programs. During Fiscal Year 1975, two reports were completed under contract that

(1) assessed the status of community planning in the alcoholism field and (2) developed a technical assistance guide to assist community organizers in the field to enhance their skills. The reports are currently being circulated for additional broad input prior to their publication and public dissemination. It is intended that these materials will strengthen the alcoholism field's resources in what has been a sparse literature area, and that the reports will be utilized in a variety of educational and training forums.

Under contract, work was completed during the year on proposed national standards for alcoholism counselors. The proposed standards were developed in response to a need in the field to systematically assess the competencies of persons providing counseling services in service programs, and to establish standards to be used in a voluntary certification program. The Institute, together with other groups, is currently examining methods for utilization of the standards through some form of national certifying body.

The Division comprises an Occupational Alcoholism Branch and a Special Projects Branch. A total of 495 grants in the amount of $69,030,000 and seven contracts in the amount of $1,830,000 were awarded in FY 1975 for programs described below.

Occupational Alcoholism Branch

Programs are designed for early identification based on impaired job performance and provision of assistance to problem drinking persons within employed populations. It possesses considerable potential for reaching increasing numbers of Americans affected by the disease of alcoholism.

State-based Occupational Program Consultants

In 1972 the Occupational Programs Branch launched a nationwide occupational consultation effort facilitated through grants made available to all States and territories for the employment of two occupational alcoholism program consultants. Occupational program consultants provide orientation and technical assistance in the development of programs, but both the form and the financing of programs at the level of the local work organization are the responsibility of those organizations, together with the labor organization that may represent and respect work forces. In all but two instances (Idaho and Wyoming) these grants would normally have expired in FY 1975. Those with unexpended funds remaining were authorized to use these funds for that purpose during the current fiscal year. Thirty six (36) states have continued this activity with their own funds after these grants expired in June 1975. Ten (10) of these states have expanded the effort beyond that contemplated in the original grants.

The survey, during FY 75, revealed that this program had resulted in the creation of 922 programs in industry and the public sector covering a total work force of over 3,000,000 employees. The cost of creating and maintaining these programs is the responsibility of the employers.

Occupational Alcoholism Demonstration Projects

The Occupational Programs Branch also supports a range of demonstration projects focused upon particular strategic models and problem areas in occupational alcoholism. This section briefly reviews the accomplishments of several of these projects during fiscal 1975.

During 1975, a demonstration project based in New York City began work developing techniques and management systems designed to develop greater receptivity to occupational programming concepts in major corporations headquartered in New York City.

The first phase of this effort was carried out during fiscal 1975. It consisted of a subcontracted survey of these major corporations to establish the extent of their existing occupational programming development, both at the corporate headquarters and nationwide, and to collect both qualitative and quantative data on the nature and the effective scope of these efforts. The findings indicate that less than a third of these giant corporations have employee alcoholism programs, and that many of the existing programs need considerable technical assistance to enhance their effectiveness. The next phase will be to use this data to develop the most effective strategies for diffusion of occupational programming concepts within large corporate employers and, through consultation and technical assistance develop effective occupational alcoholism programs across this range of corporations.

A project based in Denver is exploring program models for effective outreach to problem drinking members of highly professionalized occupations. This effort is dealing with a segment of the commercial airline pilots, using a range of training and orientation techniques to generate early supervisory and peer-based referrals of developing alcoholics within this population. The grantee union also provides model professional referral and follow-up services for airline pilots identified within the target population. This program is expected to have considerable application for use in other professional groups. In 1975 the Branch undertook initial exploration for such projects within the legal profession and clergy.

Another demonstration grant covering a somewhat unique work force was awarded to a large Midwestern university with is developing a model alcoholism and employee assistance program for the entire professional and non-professional staff on the six campuses of the institution. To date, successful program development in this type of professional setting has been minimal. The results of this project are expected to have considerable general value for use in other such institutions. Personnel of the Occupational Programs Branch provided consultation to other universities during the fiscal 1975 and participated in a nationwide conference on occupational alcoholism programs in universities organized by and held at the University of Delaware in June, 1975.

A large-scale project involving a demonstration grant to the National Council on Alcoholism began activities during fiscal 1975. This demonstration project is to be eventually based in 10 cities across the nation. The basic model to be employed and explored in the project is the use of peer management and labor influence in the development of occupational programs in these localities. A national labor-management advisory group has been set up as the national steering committee and this steering committee will in turn develop parallel committees at the local level in the 10 cities. By constituting these committees with the top influential personnel in both labor and management, the project will be able to explore the usefulness of this influence base as well as having the opportunity to promote the development of joint labor-management programs in work organizations based in the respective localities.

Several other projects are involved in exploring the feasibility of using labor organizations as the motivating force for occupational program development. One based in Missouri and involving the cooperative support of all segments or organized labor in the state, uses teams of experienced union members with consultation training and prior alcoholism experience to develop and implement labor-management agreements in organized shops in the many urban areas of missouri. Responsibility for operating individual programs is vested in a joint labor-management committee at the local plant level.

A nationwide professional association of occupational alcoholism consultants and company program administrators was the recipient of another demonstration grant. This organization has conducted several surveys on the extent of occupational program development nationwide and on the location, background, and qualifications of personnel employed in this field. The association has also subcontracted with a research organization to conduct a comprehensive study of the costs and benefits of occupational alcoholism programs in a representative set of 16 organizations located throughout the nation. The subcontractor assembled a panel of experienced program and research personnel in the fall of 1974 to assist in the design of the project. During fiscal 1975 the subcontractor also produced a summary paper on progress and development in occupational programming as well as two extensive annotated bibliographies of the professional and scientific publications in occupational alcoholism. These were distributed to the occupational alcoholism community. This association now has a dues-paying membership of nearly 1,000 members.

Several demonstration projects are exploring the feasibility of developing mechanisms to generate self-referrals among employed program drinkers and thier dependents. These include the use of "hot lines" whereby the employees and dependents may receive confidential assistance and other referral information over a 24-hour telephone line manned by professional counselors. One such project, based in Philadelphia, has enjoyed widely publicized success in its use of this mechanism for employees in several departments in that city as well as in private enterprise.

Monitoring Evaluation and Research

The Branch undertook extensive monitoring, evaluation, and research efforts related to its field of operations, through contractors.

Health Employee Assistance Program

Another activity has been the design and administration of the Employee Assistance Program for the nearly 45,000 employees of the six agencies making up the Public Health Service within HEW.

During FY 75 the Occupational Alcoholism Branch funded 25 grants in the amount of $3,346,000.

Special Projects Branch

The Special Projects Branch supported direct project grants in fourteen different program categories: Aged, American Indian, Black, Criminal Justice, Cross-Population, Comprehensive Staffing, Drinking Driver, Migrant Workers, Poverty, Public Inebriate, Spanish-American, Women, Youth and non-categorical. Additionally, the Special Projects Branch has grant responsibility with NIDA for several alcohol/drug abuse projects funded in FY 1975. A total of 470 projects received support in the amount of $65,684,000 during FY 1975.

Staffing and Cross-Population Programs

During FY 1975, 44 staffing grants were provided continued support to conduct comprehensive alcoholism treatment and rehabilitation services programs. Programs funded under this mechanism are required to provide a specific range of services including inpatient, outpatient, intermediate and emergency care as well as consultation and education services. Funds under this program supported initial salary costs of professional and technical personnel. Although this grant mechanism is no longer utilized by NIAAA, the Institute continued its commitment to the 44 previously funded staffing grants for a total dollar amount of $10,423,000 in FY 1975.

Cross-Population programs, which are direct project grants, are utilized by the Institute in lieu of staffing grants to enable communities, which wish to serve more than one target population through a single program, to utilize the various guidelines of the Institute that pertain to special population groups in a flexible manner as determined by the needs of the alcoholic population. This is in keeping with the Institute's policy of directing the focus of communities to the needs of alcoholic people rather than the needs of institutions or particular service systems. In FY 1975, 155 Cross-Population applications were reviewed and 22 programs received support amounting to $5,863,000.

The American Indian Program

Recognizing the special severity of alcoholism problems among American Indians, the Institute made support of alcoholism programs for this population a top priority in FY 75.

The primary FY 1975 objective of the American Indian alcoholism program was to assist in making the best alcoholism treatment and rehabilitation services available at the community level. To accomplish this objective, each program was designed to provide a variety of services, which included residential care, and room and board for problem drinkers seeking help--individual counseling, job placement, referral service, group therapy, Indian AA groups, didactic lectures, work therapy, recreation and self-government. Broad programs of public education, training of Indian people, and development of community services were also offered.

Since their inception, the Indian alcoholism programs have had a significant impact upon the attitude of Indian people toward drinking--the first vital step in recovery. The communities and Indian tribes living on reservations have gained valuable knowledge about alcohol abuse and are not viewing alcoholism as a major social, cultural, and economic problem. In addition, some alcoholism programs were developed without Federal funds, and community resources were organized in a concerted effort to meet the needs of Indian people afflicted by alcoholism.

The American Indian Commission on Alcohol and Drug Abuse (AICADA) continued to provide technical assistance to isolated American Indian communities on and off reservations.

During FY 1975, 129 Indian applications were reviewed and 148 projects (new and continuations) were funded at a level of $16,641,000.

Poverty Alcoholism Program

The community Alcoholism Services Poverty Program is a component of the Special Projects Branch within the Division of Special Treatment and Rehabilitation Programs. This program was initiated officially on May 7, 1972, concurrent with the transfer of 185 Alcoholism Recovery Projects from the Office of Economic Opportunity to the National Institute on Alcohol Abuse and Alcoholism.

The intent of the program is to support special projects that demonstrate how a variety of services can be made available, and be effectively utilized, by the poor alcoholic person and his family; it is intended to demonstrate that the poor can be integrated into existing health and social service systems.

During FY 1975, 93 poverty applications were reviewed and 172 poverty projects (new and continuations) were supported in the total amount of $15,326,000.

Black Alcoholism Program

Blacks are a minority group experiencing deprivation, and heavy drinking has accentuated or been a response to such hardships as limited access to jobs, poor housing and education, and inadequate medical care. In an effort to respond to the needs of this special population, the Institute in FY 1975 placed priority emphasis on funding support for projects targeted on Blacks.

During FY 1975, 32 Black applications were reviewed and 10 projects were funded in the amount of $3,336,000.

Spanish-American Alcoholism Program

The significant number and size of Spanish-American communities in the U.S. and Puerto Rico and the unique needs of this bicultural and bilingual population are bases for this Program.

During FY 1975, 40 Spanish-American applications were reviewed and 10 Spanish-American projects were supported in the total amount of $1,689,000.

Migrant Farmworkers Alcoholism Program

Migrant and seasonal farmworkers have been one of the most neglected special population groups. Because of such handicaps as poor housing, unemployment and underemployment, poor education background, poor health care and discrimination, they have a high alcoholism potential.

During FY 1975, eight applications were reviewed and one migrant farmworker project received support totaling $170,000.

Women's Alcoholism Program

The Institute initiated and supported projects designed to meet the special treatment and prevention needs of women who suffer from alcohol abuse and alcoholism. Services in these programs were tailored to the full-range of problems specifically encountered by women, whether married or single, employed or unemployed, and at any stage of physical and psychological debilitation.

During FY 1975, thirty-three women's applications were reviewed and thirteen women's projects, eight of which are new, were supported at a level of $1,874,000.

Youth Program

Surveys reveal that the use of beverage alcohol is now almost universal among American youths of high school age. The incidence of alcohol abuse among young people has prompted the Special Projects Branch to move toward the development of guidelines for this program and to begin to support treatment and rehabilitation projects as components of larger existing programs of services to troubled youths.

During FY 1975, ten youth applications were reviewed and 7 youth projects received support in a total of $2,195,000.

Drinking Driver Program

Close collaboration with the National Highway Traffic Safety Administration was maintained for projects which provide drinking driver treatment funds for communities which mount drinking driver identification programs. This mechanism provides a unique means of early detection and intervention in dealing with problem drinkers.

As the projects were implemented, arrests increased and alcohol-related accident rates decreased. More judges and prosecutors became convinced that the interacting system has merits and it helped to create cooperative relationships among the courts, law enforcement personnel and the Alcohol Service Program of the communities. The health care system in most communities benefited from the introduction of new alcoholism treatment facilities and additional funding from NIAAA.

Seventeen drinking driver new and continuation projects were funded in FY 1975 in the amount of $2,689,000. Twenty-three applications were reviewed in that year.

Public Inebriate Program

The general objective of the Public Inebriate Program is the rehabilitation of individuals with a drunkenness problem, particularly those living in the subculture of Skid Row. For many individuals the goal of improvement is limited, but some have been significantly helped to avoid deterioration and others to improve their level of functioning sufficiently that they may live outside of the subculture.

Eleven public inebriate projects received support in the amount of $2,792,000 during FY 1975. Twenty-three such applications were reviewed in that year.

Criminal Justice Alcoholism Program

The criminal justice population is defined as all pretrail releases, probationers, inmates and parolees who are charged with or convicted of any offense other than simple public intoxication or driving while under the influence of alcohol. It is estimated that the prevalence of alcohol abuse and alcoholism among the criminal justice population as so defined is eight times higher than among the general population. Project grants for services tailored to meet the special needs of this population are being awarded, and the Institute is also committed to coordinating its efforts in this area with other Federal agencies, principally the Law Enforcement Assistance Administration of the Department of Justice.

In FY 1975, thirteen applications were reviewed and six criminal justice alcoholism projects were supported with $1,431,000.

Program for the Aged

During FY 1975 one grant was awarded at $116,000 for a survey of problem drinking among the aged.

Joint Alcohol and Drug Abuse Programs

Cooperatively with NIDA the Special Projects Branch was involved during FY 1975 in the review of 35 joint alcohol and drug abuse treatment project applications. Few applicants responded to the emphasis in the guidelines on the importance of high-quality evaluation components. During FY 1975, two such projects were funded from this Branch for a total of $1,086,000.

Non-Categorical Program

The non-categorical program embraces all projects which do not fit within the definitions of the other programs of the Special Projects Branch noted above.

During FY 1975, ten such applications were reviewed and one project was funded for a total of $53,000.

DIVISION OF PREVENTION

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has established two overall principal objectives, one immediate and the other long range. The immediate goal is to make available treatment and rehabilitative services to alcoholic people and problem drinkers by mobilizing existing resources at the Federal, State and local level and developing a broad range of community alcoholism treatment and rehabilitative programs.

The second and longer range goal was the development of effective and practical methods of preventing the abuse and misuse of alcoholic beverages and the testing and evaluating of the effectiveness of these methods.

The Division had the responsibility for Youth Education, Community Prevention and Training, and for supervising the activities of the National Center for Alcohol Education.

A total of $10,266,000 was expended for Prevention grants and contracts in FY 1975. This consisted of 46 grants funded in the amount of $5,899,000, of which 18 were for Youth Education grants amounting to $2,880,000, and 28 were for Community Prevention grants amounting to $3,019,000, and seven contracts in the amount of $4,367,000.

Youth Education Branch

In order to prevent increasing numbers of alcohol abuse problems among the nation's youthful population, a number of factors must be considered. These include: educational and informational needs, environmental and social factors, physiological and psychological needs, and legal and economic realities. One isolated approach will probably not be successful in reducing alcohol problems. However, through its leadership role in attempting to develop strategies to reach children and youth, the NIAAA has been able to initiate efforts on a number of different levels.

During FY 75, the Youth Education Branch has attempted to identify and pursue a wide variety of conduits for reaching youngsters. These conduits have included parents, peers, teachers, health care providers and other adults who are recognized by youngsters as role models or leaders. During this period the Youth Education Branch reviewed 54 grant applications, of which 18 were funded in the amount of $2,880,000, 24 were disapproved and 11 were deferred to further development. The staff continued to work closely with the 18 funded grants, providing the project directors as well as other individuals active in the field with the latest materials available for working with youth. These have included an updated education bibliography and audio visual guide, as well as new resource materials including "Alcohol and Alcohol Safety", "Teaching About Drinking", "Teenagers: The New Alcoholics", "You and Your Alcoholic Parents", "Drinking Myths", and "Becoming Naturally Therapeutic." Also during FY 75, the University of Michigan under a grant from NIAAA, completed the development of 6 trigger films to be used with high school students. During FY 76, these will be distributed through the National Clearinghouse for Alcohol Information (NCALI).

In addition to the above two new major program activities were developed and implemented by the Youth Education Branch during FY 75 with the support of the NCALI's Information Dissemination Program. These have included outreach efforts directed toward national youth serving organizations and a second effort directed toward college and university campuses.

While these two efforts have not represented major commitments of funds, they have amassed impressive results in terms of interest generated and programs initiated by the groups with whom we have had contact.

A National Youth Conference was held on March 21-23, 1974 attended by representatives and leaders from 46 national youth groups. As a result of this Conference, 15 of the most interested organizations were selected for continued follow-up in incorporating alcohol education into some of their ongoing programs.

Under the project entitled "University 50 + 12", 63 campuses were visited for the purpose of initiating dialogue around the topic of drinking practices on the college campuses. Data was collected concerning programs already in progress and information about alcohol and alcohol problems was distributed to the students, faculty and administrative representatives. A liaison person for continuing communication with NIAAA was designated by the president of each university. As a result of these visits, an Editorial Board has been formed and staff at the NCALI are currently in the process of developing a handbook of prevention models which can be implemented on university campuses with limited resources. A national seminar planned for November 21-23, 1975 at the University of Notre Dame in Southbend, Indiana will be convened for the purpose of stimulating interest in the handbook and training liaison representatives and students in methods to implement the models described in the handbook.

In addition to the 18 grants in the amount of $2,880,000, one contract in the amount of $250,000 was supported to develop community informational and follow-up components of alcohol segment of TV health series and one modification of $11,000 to an existing contract to the National Congress of Parents and Teachers for the development and implementation of an alcohol education program for parents and school children. The total contract to the National Congress of Parents and Teachers amounted to $10[illegible]5, of which $97,765 was awarded in FY 1974.

Community Prevention Branch

The goal of the Community Prevention Branch is the development of effective programs in preventing the misuse of alcoholic beverages. Its concerns are the health education of the community in regard to the use, misuse and nonuse of alcohol. The scope of its activities are directed to the entire community population.

During Fiscal Year 1975, the Community Prevention Branch continued to encourage more comprehensive prevention programming as indicated in our Statement of Policy which includes: altering the social environment, strengthening community resources and strengthening individual resources. The Branch particularly encouraged the development of those projects that highlighted the public character of alcohol problems, showing it to be a community problem, as well as an individual one, requiring a comprehensive approach to its mitigation.

A major endeavor of the Community Prevention Branch during FY 1975 was the designing of a program to train State Prevention Coordinators in the area of primary prevention activities. Twenty-four coordinators were trained. Two groups of twelve attended two phases of training that were separated by several months of field experience. In this program the coordinators were prepared for giving direction to programming related to public education, public discussion, a community study of its drinking patterns, the development of strategies to prevent drinking problems and other actions designed to minimize the abuse of beverage alcohol.

Yearly work plans were submitted the State Prevention Coordinators stating their plans for a twelve month period. Quarterly reports also were submitted outlining their plans in the area of public education, public dialogue, assessment of needs, analysis of community drinking patterns and the recommendations of the communities for modifying their local drinking patterns.

The number of grant applications received by the Community Prevention Branch during the Fiscal Year were fifty-four. Twenty-eight applications were approved and funded at a cost of $3,019,000.

In addition to the 28 grants, the Branch supported four contracts in the amount of $437,535. One contract in the amount of $295,160 was awarded to conduc a study of actual effects of alcohol beverage control (ABC) laws and to determine if the role of the law can be used as a prevention strategy. The remaining three contracts were related to activities conducted through the Clearinghouse - one in the amount of $62,275 to develop printed materials on alcoholism in Spanish; one in the amount of $78,624 to maintain stocks of NIAAA brochures in racks in supermarkets in various cities primarily along the East Coast; and one was a modification in the amount of $1,476 for writing of brochures on prevention, presentation of slide shows on prevention for the Navy, and writing of fact sheet on various aspects of alcoholism for the Clearinghouse. This was a modification of an existing contract that was awarded in FY 1974. Including the cited modification, the contract amounts to $17,176.

National Clearinghouse for Alcohol Information (NCALI)

The National Clearinghouse for Alcohol Information is an information service of NIAAA -- established to search out worldwide information on alcoholism prevention, treatment and research, and to share this knowledge with the professional community and the general public.

Fiscal year 1975 was NCALI's third full year of operation. It was funded during this time by a $3,669,000 cost-plus-award-fee contract with the General Electric Company. During the year the contract was opened up for competitive bidding, and proposals for the operation of the Clearinghouse were submitted by various firms. At the conclusion of a technical review and evaluation of the proposals, the contract was again awarded to the General Electric Company.

During FY 1975 the Clearinghouse continued its efforts to provide such services as:

- -- Engaging in an aggressive outreach program to seek potential users of Clearinghouse services.
- -- Publishing an Information and Feature Service and a quarterly bulletin offering news of developments and state-of-the-art reports.

-- Assembling bibliographies on various aspects of alcohol and alcoholism and supplying abstracts of studies in specific alcohol-related areas.

-- Spreading the NIAAA theme of responsible drinking through public service announcements, posters, and other materials distributed for use by local alcoholism groups and the media.

-- Assisting NIAAA's prevention program through an Information Dissemination Program designed to enlist the aid of such organizations as universities, industries, and national youth organizations in the campaign against alcoholism.

Acquisition and Processing of Literature

As an information center, the Clearinghouse collects literature on all aspects of alcohol and alcoholism from all possible sources around the world. NCALI's information system centers around a reference library and a data repository which contain more than 46,000 items, including books, audio-visuals, journals, magazines, lay literature, microfilm and abstracts of documents. During FY 1975, some 5,300 items were added to the collection, ranging over such fields as research, education, grant information and legislation. The reference library is used by NIAAA and by researchers from around the world.

The information is gathered, processed, analyzed and entered into a computer data base. A Quality Evaluation System, initiated in FY 1974 and refined during FY 1975, evaluates literature acquired by the Clearinghouse.

Reference Services and Processing of Requests

The Clearinghouse reviews and processes thousands of requests each month from researchers, physicians, alcoholism counselors, program administrators, clergy, educators, students and the general public. IN FY 1975, NCALI answered 127,000 requested with 3,620,000 information items.

During FY 1975, the Clearinghouse reference service completed work on State Fact Finders for all states and outlying U.S. territories. These summaries are used by State alcoholism agencies, program administrators, Congress, and others to obtain current information on alcohol legislation, finances, personnel, and programs in each State.

Current Awareness Services and Materials

The Current Awareness Service is responsible for providing key groups in such fields as medicine, law enforcement, social work and industry with greater knowledge and insight into the alcoholism problem. The purposes of Current Awareness are to search out new users of Clearinghouse services and to keep registered users up to date on new developments.

To help workers in the alcoholism field keep abreast of recent developments, the Clearinghouse prepares two publications. An Information and Feature Service provides brief reports on treatment and prevention, new publications, meetings, grants and other information. During FY 1975, mailings reached 52,000 registered users. A quarterly bulletin, Alcohol Health and Research World, provides in-depth information on such topics as alcohol and women, and research and treatment innovations. A total of 42,000 bulletins were sent out in FY 1975.

Current Awareness Service provides two additional channels to keep its users informed. Grouped Interest Guides are bibliographic updates of new documents in 15 categories. During FY 1975, Guides were mailed on a scheduled basis to an average of 5,600 persons (29,905 GIG's per mailing). Individualized Interest Cards are issued monthly and allow subscribers to be more selective in choosing topics of interest. In FY 1975, Individualized Interest Cards were mailed to an average of 5,500 persons per month. Through its varied services and materials, Current Awareness contacted more than 121,000 potential users during FY 1975.

Information Dissemination Program

During FY 1975, the Clearinghouse expanded and strengthened its Information Dissemination Program. At the core of this program is a plan to communicate NIAAA messages through such organizations as industrial firms, schools, colleges, service clubs and professional groups. The goal is to make these organizations aware of the impact of alcoholism and alcohol-related problems in America and to get their commitment to taking action.

The following are highlights of various projects undertaken in FY 1975 as part of the Information Dissemination Program:

1. Radio and TV Spot Distribution. IDP staff undertook personal deliveries of NIAAA public service announcements to stations across the country to insure saturated distribution and maximum airtime, to motivate increased broadcast programming at local levels, and to involve State and local alcohol organizations in distribution of spots to stations.

2. Sunday Supplement. A publication on alcohol was prepared and disseminated as a test case in the Sunday Columbus Ohio Dispatch. The purpose of this project was to replace popular myths about alcohol with facts, promote responsible decision making about alcohol to a large public audience and to evaluate the use of supplements in newspapers as an educational device.

3. University 50 + 12. During FY 1975, Clearinghouse staff visited 63 major universities (minimally one in each State). The main objectives of the visits were to disseminate alcohol information to universities, to foster the establishing of alcohol-related projects on campus, and to gather information about existing projects. The material and program ideas collected during the visits were drafted into a University Program Manual to be used by faculty and student groups in setting up alcohol education projects on campus. Follow-up plans for FY 1976 include holding a seminar focusing on how to use the manual, and expansion of the program to additional universities.

4. Youth Organizations. The objectives of this project are to develop creative ideas for programs which youth organizations can implement, to involve members of youth organizations in alcohol-related projects, and to integrate alcohol education activities into organizations' existing programs. As part of this effort, a national "Face to Face" conference was held in Washington, D.C., bringing together youth and adult representatives from some 60 national youth organizations.

5. Women and Alcohol. During FY 1975, the Clearinghouse began a special effort to focus the attention of the media on the problem of women and alcohol abuse. As part of this project, NCALI developed a multi-media package for dissemination to broadcast/print media and broadcast industries and prepared a special information package on alcohol and women for national women's organizations. As a result of this effort, a number of network and nationally syndicated radio and television programs were produced, including a segment of the Mike Douglas Show.

6. Foundations. The goal of this project is to encourage foundations to include alcohol considerations in areas already being funded, such as child abuse, and to set a climate among selected foundations which will be receptive to funding new alcohol-related activities. During FY 1975, NCALI researched 75 foundations and conducted in-depth interviews with executives of 30 of the most promising organizations. Ten of these were selected to begin establishing a "working partnership" with NIAAA which would ultimately lead to sources of funding for alcohol programs.

7. Field Representatives. During FY 1975 the Clearinghouse initiated a pilot project in Texas to test the feasibility of maintaining regional staff to help implement IDP projects on the local level. The success of the pilot project led to the establishment of five field representatives around the country. The priorities of the field representatives include building a communications network throughout each sector and developing and implementing NIAAA/NCALI projects that have broader application and can be replicated in other states.

Other Clearinghouse Programs

The Clearinghouse operation encompasses several other programs and support services, including the following:

- -- NCALI serves as a Clearinghouse for the Department of Transportation's National Highway Traffic Safety Administration (NHTSA). This project involves warehousing of NHTSA standard pamphlets, responding to NHTSA inquiries from the general public, responding to technical inquiries involving searches and correspondence, and including technical articles in Clearinghouse publications.
- -- The Clearinghouse supports NIAAA's inter-agency agreement with the U.S. Navy's Alcoholism Prevention Program through the preparation and dissemination of special information material, as well as inclusion of all pertinent Navy installations on NCALI mailing lists.

-- The Clearinghouse maintains a program of quality assurance to assess the overall operation, performance and adequacy of services. This group is concerned with the timely and appropriate response to all inquiries, as well as with the Quality Evaluation System to evaluate alcoholism literature.

-- The Clearinghouse provides support to NIAAA's Occupational Programs Branch in the development and dissemination of information materials to business, industry and labor.

DIVISION OF RESEARCH

Extramural Research Branch

During FY 75, the Extramural Research Branch was responsible for reviews of 263 requests for research grants for projects on a wide variety of problems associated with the use and abuse of alcohol. Seventy-four applications for new and renewal grants were recommended for approval which, added to thirty-four approved applications carried over from previous fiscal years, totals 108.

By the end of FY 1975, 159 grants and contracts were awarded totaling $10,681,000. Of these awards, 79 were continuations in the amount of $5,690,000, 24 competing renewals for $2,260,000, 53 new grant awards for $2,332,000, and three contracts for $229,000. Supplemental awards, including a chairman's grant, amounted to $170,000.

Grants for University-Based Centers

During this FY 75 period, funding was continued for one university-based center to support the multidisciplinary research of alcoholism as it relates to such areas as aging, suicide, criminality, genetics, psychology and physiology in both humans and animals. Continuation funds were also provided to a former center to complete clinical studies involving psychotherapy, and genetic-biological correlates of alcoholism.

Biomedical Studies (Biological)

Almost half of the Research Division grants were awarded for basic and applied biological research of alcohol effects. Projects studying the etiology of liver cirrhosis and other alcohol-related diseases have been very successful; therefore, continued research in this area is being conducted. Also, new projects in the areas of alcohol and drug metabolism, biogenic aldehydes as it relates to addiction and alcohol-induced losses in mnemonic efficiency promise to yield greater insight into the physiological mechanisms of addiction and chronic loss of memory.

Continued research of intra-uterine effects of alcohol was emphasized by the funding of two new projects to study alcohol intake in pregnancy and the offspring's development, and offspring survival and behavior as a result of maternal ethanol consumption.

Behavioral Studies

Areas of high priority in the field of behavior continue to include studies on drinking practices and attitudes toward alcohol among teenagers and youth. Parallel to the Institute's interest in intra-uterine effects of alcohol was the awarding of two additional grants for the study of the effects of alcohol on perceptual and cognitive performance during the menstrual cycle and research into the definition and interaction of a wife and her alcoholic husband.

Studies of Treatment (Clinical)

The Extramural Research Branch continues to realize the need for improved methods of treatment. To this end funding is maintained for the ongoing studies on lithium and disufiram in the treatment of chronic alcoholism. In addition, two new aspects of the behavioral-psychiatric approach to treatment include the studies of transcendental meditation and relaxation procedures as therapy for alcoholism. Preliminary results in this area have been very promising, indicating the need for more emphasis on this approach.

Prevention and Education, Community Research, and Epidemiological Studies

The remaining grant research categories funded in FY 75 focused on prevention and education, community system and epidemiological studies. A new project is in progress involving liquor control that will determine the relationships between types of Alcohol Beverage Control (ABC) systems and mean consumption levels, and also another project studying the drinking patterns and criminal careers will offer greater insight into the identification of likely alcoholic candidates. Renewed interest was shown in Ethnic Studies which warrants the continuation of research efforts in the areas of drinking problems among urban Indians, in rural communities and black collegians.

Intramural Research Programs

Laboratory of Alcohol Research

During FY 1975, the work of the Laboratory of Alcohol Research was reviewed by a committee of scientists from outside the Institute. Again during FY 1975, a distinguished committee of outside scientists, which included three Nobel laureates, met and made recommendations for the program of the Laboratory. Their recommendations are summarized as follows:

-- The effectiveness of the program is severely compromised by the location of the Laboratory at St. Elizabeths Hospital, and it should be moved to a site either on or near the main NIH campus, where scientific interaction and general hospital facilities are available for the care and study of medical complications of alcoholism.

- The Laboratory should continue its policy of regular reviews by panels of independent outside scientists, who should evaluate the competence and relevance of the work of the Laboratory, make suggestions for new programs and personnel, and recommend termination for programs and personnel which in their judgment are not productive.

- The Laboratory should continue its efforts to attract scientists of the highest caliber from a number of disciplines, to conduct research on problems of the most fundamental nature and the greatest degree of difficulty which are currently soluble, and to serve as a source of scientific and technical information to those charged with administering the overall programs and formulating policy for the Institute.

- The Laboratory should serve as a training program for a limited number of professionals who plan to make a career of either research in, or care of patients suffering from the consequences of alcohol abuse.

To implement the recommendations of the review panel, the following steps have been taken:

- The Institute is currently negotiating for space for the care of a small number of patients and conduct of research on the medical complications of alcoholism, to be allocated from within the space currently occupied by ADAMHA within the Clinical Center of the NIH. Additional rental space to house the remainder of the Laboratory is being sought near the NIH campus.

- Sixteen new positions for the Laboratory have been requested for FY 1976 (in addition to the ten positions existing during FY 1975), along with significant budget increases.

- Four research sections as originally planned have been requested for the Laboratory: Metabolism, Psychology, Neuroscience, and Clinical Research. Recruiting efforts to staff these sections are underway, but remain severely hampered by the limitations on space. The Metabolism program, already active in FY 1974, continues to be the only functioning program of the Laboratory, although a senior psychologist was appointed late in FY 1975 to initiate the Psychology research program.

Metabolism Program

Alcoholism, while not classified as a metabolic disease because alcohol is largely exogenous in origin, nevertheless closely resembles a metabolic disorder in its course. The initial research of the Metabolism program focuses on problems related to the toxic effects of alcohol on a number of metabolic systems. The first of these areas is the relationship of ethanol to fat metabolism. In particular, the Laboratory is investigating the mechanisms whereby ethanol ingestion leads to fatty liver and, in some cases, to hyperlipidemia. The second problem currently under investigation in the Laboratory is the well-known shift of the redox state of the cytoplasmic pyridine nucleotides during alcohol ingestion. It is suspected that this fundamental change induced by alcohol is involved in the numerous abnormalities seen after alcohol consumption, including decreased urea synthesis, decreased protein synthesis, decreased glucose synthesis, and decreased oxidation of fats. The third major line of investigation within the Laboratory bears on the interpretation of the measured values of aldehydes in biological material. There are currently a number of major hypotheses which place measured acetaldehyde (the first substance produced during the metabolism of alcohol) in a central position in several aspects of alcoholism and alcohol-related problems. However, measurements of this metabolite are extremely difficult and at this time remain technically unsatisfactory. The Laboratory is currently attempting to resolve some of these difficulties so that these interesting and medically relevant hypotheses may be experimentally tested.

Laboratory staff have also been pursuing investigations of the mode of alcohol's action upon brain by utilizing an animal model of withdrawal developed earlier in this Laboratory. These studies include investigations of the effects of alcohol on neurotransmittors, tests of the effectiveness of various chemical agents in ameliorating the alcohol withdrawal syndrome, and attempts to determine the source of the methanol or "wood alcohol" which accumulates in the body during prolonged alcohol intoxication.

Psychology Program

Initial plans have been developed during FY 75 for this new program and call for research into some of the behavioral and hormonal events occuring during important periods of development of the individual and the effects of alcohol during those periods. There is good reason to believe, for example, that there may be profound and tragic effects on the developing fetus when the mother drinks heavily during pregnancy. Another critical period occurs during the onset of puberty, when the individual undergoes major psychological and endocrine changes and a sudden spurt in physical growth occurs. While little is now known concerning possible lasting effects of alcohol consumed during this period, it is a topic of great importance, especially in light of recently reported increases in teenage drinking in this country.

The Psychology program will also investigate mechanisms underlying the influence of certain environmental influences on alcohol consumption. It is known, for example, that the laboratory rat will drink significantly more alcohol if it is housed in complete darkness. Since darkness is known to influence various neuroendocrine systems of the organism, it may be possible to elucidate a relationship between such systems and the regulation of drinking behaviors. Another environmental factor which will influence the amount some animal species drink is the schedule of feeding. A technique to induce increased alcohol intake in the normally resistant rat has been developed from this finding and is known as "schedule-induced polydipsia." This technique will be useful in studying behavioral and hormonal causes and effects of alcohol consumption in laboratory animals.

Studies with human subjects must await the availability of appropriate research facilities.

Neuroscience Program

Studies will be directed toward understanding the basic mechanisms governing neurologic complications of alcohol addiction and withdrawal, including molecular components involved in each of these processes. In addition, investigations will be conducted of genetic factors influencing alcohol consumption. Initiation of this program awaits the availability of space and subsequent recruitment of staff.

Clinical Research Program

This program will be concerned with the treatment and care of individuals with alcohol-related diseases of the liver, brain, and heart, in a general hospital setting. In addition, it will perform research on alcoholic patients designed to elucidate the clinical disease states induced by alcohol consumption and will serve as a national center for training individuals in the care and treatment of alcoholic persons. This program, of crucial importance to the future development of the Laboratory, requires that appropriate space for clinical research with a small number of patients be obtained in a general hospital setting, such as the Clinical Center at NIH.

Publications

Of the four programs described above, only the Metabolism program was functional during FY 1975. Publications resulting from the work of this group are as follows:

Short and Long Term Effects of the in vivo Administration of Ethanol Upon Rat Liver HMG-CoA Reductase and Cholesterol 7 Hydroxylase (Submitted to J. of Lipid Research). M.R. Lakshmanan and R.L. Veech (1975).

Measurement of the Rate of Rat Liver Sterol Synthesis in vivo Using Tritiated Water. (In preparation for J. Biol. Chem.). M.R. Lakshmanan and R.L. Veech (1975).

Effects of an Acute Dose of Ethanol Upon the Number of Tritium Atoms Incorporated into Cholesterol During its Biosynthesis from Mevalonate by Rat Liver in vivo. (In preparation for National Council on Alcoholism Symposium). M.R. Lakshmanan and R.L. Veech (1975).

Stoichometric Hydrolysis of Long Chain Acyl-CoA and Measurement of the CoA Formed with an Enzymatic Cycling Method. Analytical Biochemistry 62, 449-460. Veloso, D. and Veech, R.L. (1975).

Enzymatic Determination of Long-Chain Fatty Acyl-CoA. Methods in Enzymology, p. 273. Academic Press, New York. Veloso, D. and Veech, R.L. (1975).

Equilibrium Constants and Michaellis Constants for Mitochondrial Enzymes. In Handbook of Cell Biology. (Altman, P., Ed.). Fed Am. Soc. Exp. Biol., Bethesda (in press). Cornell, N. and Veech, R.L. (1975).

Modifications of the enzyme assay for inorganic phosphate. (In preparation for Anal. Biochem.). Cornell, N. and Veech, R.L. (1975).

The Cause of Inhibition of gluconeogenesis by ethanol. (In preparation for Biochem. J.). Cornell, N., Lund, P., Stubb, M., and Krebs, H. (1976).

Enhancement of the Inhibitory Effects of Ethanol on Fatty Acid Oxidation by Lysine. (In preparation for Biochem. J.). Cornell, N. and Harris, R. (1975).

The variation of the equilibrium constants of the glyceraldehyde 3-phosphate dehydrogenase and 3-phosphoglycerate kinase reactions with free magnesium concentrations. (In preparation for Biochem. J.). Cornell, N., Leadbetter, M., Krebs, H.A., and Veech, R.L. (1976).

Biochemical Pharmacology of Ethanol (1975), Adv. in Exp. Med. and Biol., Vol. 56. Plenum Press, New York. (Majchrowicz, E., Ed.).

Alterations in the turnover of brain norepinephrine and dopamine in alcohol dependent rates. J. Neurochem. 23, 549-552, 1974. Hunt, W.A. and Majchrowicz, E.

Metabolic correlates of ethanol, acetaldehyde, acetate and methanol in humans and animals (1975). In Biochemical Pharmacology of Ethanol pp. 111-140, Plenum Press, New York. (Majchrowicz, E., Ed.).

Induction of physical dependence upon ethanol and associated behavioral changes in rats. Psychopharmacol. 43, 245-254, 1975. Majchrowicz, E.

Effect of peripheral metabolism on the central nervous system. Fed. Proc. 34, 1948-1952, 1975. Majchrowicz, E.

Brain concentrations of biogenic amine metabolites in acutely treated and ethanol dependent rats. Submitted for publication in the British Journal of Pharmacology. Karoum, F., Majchrowicz, E., and Wyatt, R.

Measurement of malonyl coenzyme A. Methods in Enzymology 35:312-315. Guynn, R.W., and Veech, R.L. (1975).

Decreased rate of glucose utilization by rat brain in vivo after exposure to atmospheres containing high concentrations of CO_2. J. Neurochem. 24:1-6. Miller, A.L., Hawkins, R.A., and Veech, R.L. (1975).

A comparison of the metabolic effects of bovine growth hormone and growth factor from spirometra mansonodies on rat liver in vivo. J. Toxicol. Environ. Health 1:2-14. Veech, R.L., Hawkins, R.A., and Nielsen, R.C. (1975).

Effects of polychlorinated biphenyls and thiamin deficiency on liver metabolism in growing rats. J. Toxicol. Environ. Health 1:91-105. Berdanier, D.C., Tobin, R.B., Nielsen, R.C., Mehlman, M.A., and Veech, R.L. (1975).

The effects of acute ethanol intoxication on cerebral energy metabolism. In Alcohol Intoxication and Withdrawl: Experimental Studies II, (Gross, MM. ed.) pp. 93-109. Adv. Expt'l Med. & Biol, Vol. 59, Plenum Press, New York. Nielson, R.H., Hawkins, R.A., and Veech, R.L. (1975).

A possible role for pyrophosphate in the control of hepatic glucose metabolism. In Gluconeogenesis (Mehlman, M.A., and Hanson, R.A., Eds.) Wiley, New York. (In Press). Lawson, J.W.R., Guynn, R.A., Cornell, N., and Veech, R.L. (1975).

Research plans and goals of the Laboratory of Alcohol Research. In Proc. N.Y. Acad. Sci. (Seixas, F., Ed.). N.Y. Acad. Sci., New York. (In press). Veech, R.L. (1975).

Sucrose as a stimulant of helpatic fatty acid synthesis. In Sweetners: Issues and Uncertainties (White, R.W., Ed.) pp. 113-115, National Acad. Science, Washington, D.C. Veech, R.L. (1975)

Ethanol as an environmental toxin. Proc. NCTR Conference (Archer, O., Ed.). Veech, R.L. (1975)

During FY 1975, personnel costs for the Laboratory of Alcohol Research were $232,000. Other direct operations for the Laboratory and payments for maintenance support and administrative services for the facilities at St. Elizabeths Hospital totalled $186,000. Total expenditures for this intramural research program during FY 1975 were approximately $418,000.

OFFICE OF PROGRAM DEVELOPMENT AND ANALYSIS

The Office of Program Development and Analysis analyzes and evaluates progress of programs, assists the Director, Divisions, and other key staff in establishing priorities, provides advice on program policy and development, and coordinates in the area of economics and statistics as related to intermediate and long-range program planning, and policy development issues such as national health insurance; administers NIAAA international activities; and compiles statistical information and integrates data from research programs, program analyses, program evaluation, biometric surveys, and other sources for the preparation of major scientific reports.

The office consists of two branches - Program Development and Planning Branch and Program Analysis and Evaluation Branch.

Program Development and Planning Branch

Third Party Reimbursement Activities To Increase Health Insurance Coverage For Alcoholism Treatment

Though progress has generally been made over the past year in recognizing alcoholism as a very critical health problem, still insurance coverage for this illness has been very slow in developing. Thus far, third party payments usually continue to exclude or highly limit coverage for the treatment of alcoholism, putting great financial stress on alcoholics seriously seeking treatment, and inhibiting others who might seek treatment if readily available. Even those health insurance policies which do cover alcoholism limit it to a general hospital, thus excluding many types of more economical treatment programs.

In NIAAA supported programs, the average patient has a 14 year drinking history, which adequate insurance coverage could have prevented. Further, the prognosis for complete recovery at this late stage is quite low, and treatment costs are very high. NIAAA supported programs currently receive about 9% of their income from all third party reimbursement services while only 2.5% of this is from private insurance.

NIAAA is working with a broad representation from the alcoholism field in an effort to meet some of the inadequacies in the third party payments area. Some of the current activities the Institute is engaged in are as follows:

Development of Standards for Alcoholism Treatment Services

Of all NIAAA activities, the accreditation of alcoholism programs may well be the most far-reaching, since the insurance industry recognizes and accepts programs accredited by the Joint Commission on Accreditation of Hospitals (JCAH). Standards have now been developed by JCAH through a contract with NIAAA, and a standards manual has been published with a procedure for ongoing surveys leading to accreditation detailed. Implementation of these standards of JCAH is beginning to assure insurance carriers, for the first time, of a quality alcoholism program; approximately 100 programs have been accredited by JCAH in the first year of the standards effort.

Counselor Certification

Running parallel to NIAAA accreditation efforts are activities aimed at certification of alcoholism counselors. This is a very complex issue with a wide range of degreed and nondegreed people working in the field, and few guidelines available for credentialing such various new specialties in the health care system.

NIAAA had let a contract to prepare model standards as a basis for certification, and over 2,000 institutions and associations reviewed the draft standards before a final report was made to NIAAA. Institute policy now is to help each State shape standards commensurate with its needs, though it does support uniformity in State certification criteria.

The NIAAA model standards suggest the following basic requirements:

a) the Counselor must have no history or evidence of alcohol or drug misuse for a minimun of 2 years.

b) the Counselor must complete a training program conducted by a certifying authority.

c) the Counselor must have one year of alcoholism counseling experience acceptable to the certifying authority.

d) the Counselor must pass an examination verifying that he possesses adequate knowledge and skills in alcoholism counseling.

Incentive Contracts

NIAAA has awarded a number of incentive contracts to profit-making outpatient alcoholism treatment centers, and it is expected that these demonstration projects will prove that such contracts can yield high quality treatment facilities which would qualify for third party payments and become self-sustaining in a short time. These centers focus primarily on occupational programs, entering into agreements with business and industry to provide therapy for employees referred by the employer.

Health Maintenance Organizations

NIAAA has provided funding for a grant with the HMO national association, the Group Health Association of America (GHAA), for the association to set up demonstration projects of broader alcoholism treatment in HMO settings. The objective is to demonstrate that services for alcoholism and related health problems can be an accepted and routine part of the care provided by an HMO. There are currently several pilot projects in operation, and GHAA has developed a research design for these demonstration projects.

Model Benefits Package

NIAAA determined that a set of model health insurance benefits was needed to help carriers determine reasonable coverage, and so a package was developed to serve as a guideline for alcoholism coverage in health insurance plans. This package will eventually be made available to all State Alcoholism Authorities, employees, unions and the insurance industry.

In developing this model, a study was conducted to provide information concerning the costs of different types of alcoholism treatment programs compared to the benefit package, and a preliminary conclusion is that it is reasonable and economical to provide care for alcoholism through the vehicle of a model benefit package. The model seems adequate for dealing with the needs of most alcoholic persons for treatment services. However, this package needs additional study and thorough testing before any large scale implementation can be attempted.

Program Analysis and Evaluation Branch

The policy of the Institute is to evaluate all major programs and to commence evaluation at program inception, where practicable, in order to ensure that the results may be available for program decision-making and to provide guidance for the planning function.

Evaluation is conducted in each functional area of responsibility of the Institute. Those functional areas include prevention, training, treatment and rehabilitation, research, and public education relating to alcohol abuse and alcoholism.

Findings from NIAAA evaluation activities have provided needed information on treatment program performance, client outcome, staff utilization, treatment benefits, and costs. Also, a system to gain information on the impact of the state formula grant program is being developed and a nationwide profile of alcoholism programs, staffing patterns, expenditures, and funding sources should be available through that source in FY-76. Other evaluations include the effectiveness of the NIAAA Public Education Campaign, a study of multi-drug use, and a survey of youth services.

Evaluative information was provided to Congress, Office of Management and Budget, State Alcoholism Authorities and other government agencies during Fiscal Year 1975.

Evaluation findings were widely disseminated through prepared papers, professional periodicals, and presentation to professional groups.

Alcoholism Treatment Program Monitoring System

A system was designed and implementation started in 1972 to monitor alcoholism treatment projects funded by the Institute. That system was expanded in FY-1975 to include projects within all programs. A total of 117 projects were monitored with all remaining NIAAA funded projects scheduled for inclusion within the monitoring system by FY-1976.

Information provided by the monitoring system shows positive changes as a result of treatment in each program area. Consumption of alcohol, behavioral impairment, and work situation reveal significant improvement at six months after the admission for treatment. Average alcohol consumption and behavioral impairment declined over 70% in most programs monitored.

Significant changes have occurred in NIAAA funded projects as a result of information gained through the monitoring system. Greater emphasis has been placed on outpatient care, which has resulted in a 73% increase in clients served in that treatment setting, and has contributed to a 38% reduction in treatment costs over the past three years.

Other benefits from treatment include a reduction in the numbers of persons institutionalized after admission to treatment for alcoholism. As shown in the tabulation below, 73% fewer perosns were institutionalized between the fifth and sixth months after treatment began than during the month prior to treatment. A portion of the institutionalization was represented by hospitalization which decreased by 68% in the Alcoholism Treatment Centers (ATCs).

The added earned income of the clients is indicative of some of the economic benefits of treatment. The employment increase of 16%, combined with an increase in monthly wage, provided over $1,052,000 during a single month measured for the group of clients in one program area.

Benefits of early intervention in the alcohol abuse pattern also was demonstrated in FY-1975. Those clients reported as drinking frequently, or heavily, for fewer than five years required less resources and were more improved after treatment than other clients. Persons drinking heavily under five years required an average of 13.7 days, when assigned to that setting, while clients reporting heavy drinking longer averaged up to 21.5 days. In outpatient care, those drinking heavily under five years averaged 19 hours treatment as compared to 25 hours for the group drinking heavily or frequently for more than five years.

*Other Client Benefits from Treatment
(Alcoholism Treatment Centers)

Reduction in clients institutionalized	(3,549)	73%
Reduction in clients hospitalized	(1,702)	68%
Increase in employment	(1,581)	16%
Increase in average monthly wage	($38)	9%
Estimated additional client income per month		$1,052,000

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*Period represented is 30 days priot to treatment vs. 30 days six months later

A reduction in client treatment costs to the individual projects over the past three years averaged 38%. This reduction was partly the result in a change of emphasis from inpatient to outpatient care, which is less expensive, as well as to increased efficiency by the treatment projects.

Client Follow-Up Study

A follow-up study of Alcoholism Treatment Center (ATC) clients was undertaken for the primary purpose of examining the effects of ATC treatment and gaining insight into aspects of treatment center operation with particular regard to the retention and follow-up of clients. A sample of 1,340 individuals from eight ATCs were surveyed 18 months after their initial contact with the centers. Some of the significant findings from initial analyses are:

-- Alcoholism is very treatable - about 70% of ATC clients show recovery at 18 months after intake. The value of early intervention, exemplified by DWI (Driving While Intoxicated) clients, is demonstrated by markedly lower severity of problems at admission and greater degree of recovery.

-- Even those clients having minimal contact with the centers show a substantial recovery rate. However, recovery rates are about 20% higher for clients receiving relatively high amounts of treatment.

-- Different types of treatment have relatively uniform effects on client recovery. The most important predictors of client outcome are client characteristics, such as socio-economic status and severity of problem at intake, rather than the particular treatment types or settings utilized.

-- Group recovery rates at 6 months after admission are very close to those measured at 18 months after admission to treatment.

-- Treated clients showed increased participation in the labor force and added income through a decrease in unemployment - as much as 50% for male, non-DWI clients.

These follow-up data have been added to an existing base derived from a routine monitoring system implemented in NIAAA-supported treatment programs. A number of additional analyses are scheduled. Furthermore, another study of this cliemt group is planned at three years after admission to ascertain longer term effects of treatment.

Public Education Campaign Evaluation

A nationwide survey was performed to determine the extent of public awareness of the NIAAA Public Education Campaign. The survey also sought to determine the attitudes and behavior of the general population regarding the consumption of alcohol.

The study findings revealed a high rate of recall of the messages of the education campaign. The high rate of recall (62%) suggests that the campaign is reaching the public, especially those persons under 45 years of age, with high school educations, and earning over $5,000 annually.

Over 90% of those polled view alcohol abuse and alcoholism as a serious problem in this country today, while 81% view marijuana use as a serious problem.

Twenty-one percent of regular drinkers began to drink on a regular basis by the age of 18. The median age for the first drink for the general population was shown as 16.6 years, for men 15.4 years. Therefore, the importance of focusing prevention and educational campaigns on that age group becomes apparent.

Evaluation of State Aftercare Efforts

A joint study with the Texas State Commission on Alcoholism and the Texas Department of Mental Health and Mental Retardation was performed on state aftercare effectiveness. The study included interviews with 900 alcoholism clients discharged from Texas state hospitals in 1971 compared to 900 alcoholism clients discharged in 1974. The later group was interviewed both at admission and discharge. The NIAAA data collection instruments were used.

The findings of the study were supportive of the NIAAA client follow-up study regarding the effects of treatments. Approximately 60% of the clients were significantly improved one year after discharge. The aftercare system is shown to provide needed services to persons suffering from alcoholism.

Evaluation Assistance to States

A grant was awarded to the Council of State and Territorial Alcoholism Authorities to assist states desiring to develop and implement monitoring systems for alcoholism treatment programs. The Institute is interested in all states developing the capability to monitor and evaluate their alcoholism programs in order to improve those services and to serve all those needing help.

This project is to provide the necessary resources to develop compatible data systems by states so requesting. Compatibility of data will allow the development of nationwide utilization rates and should foster studies of mutual usefulness to all states and to the Institute.

Formula Grant Monitoring System

A project to develop a system to measure the impact of the State Formula Grant was initiated. That system will be designed to collect data on the staffing, funding, and usage of the functional areas of training, treatment, prevention, research, and associated activities concerning the state alcoholism effort. The states will report annually. Data will be processed by the Institute and output reports will be provided to all system users.

PROGRAM COORDINATION

During FY 1975, the Associate Director for Program Coordination concentrated on the development and implementation of these objectives:

- -- To effect optimum coordination, liaison and evaluation of all NIAAA programs (including grants and contracts) as a total integrated system.
- -- To provide timely management information for decision-making to the Director and all Divisions, Branches, key staff and Regional Offices, in order to provide for optimum interaction and interfacing.
- -- To serve as the focal point of all inter-agency agreements.
- -- To improve efficiency and effectiveness by improved utilization of all NIAAA resources.

Detailed plans were developed to accomplish each of these objectives.

Management Information System

Numerous programs involving interaction across several Divisions of the Institute were coordinated and the need for programmatic functional integration became apparent at all levels of management. A Management Information System for decision-making and control was designed to serve the needs of the Director of the Institute and top management. When fully operational, it will provide (1) for overall as well as detailed functional information on all existing and proposed programs (including applications, grants, and contracts), (2) for the interfacing and interacting of all NIAAA programs and resources prior to and after award, and (3) for feedback information on efforts and expenditures for decision-making and control. This system will present the workload of the functional and subfunctional programs, manpower and financial resources committed, progress, actual expenditures and actual end performance results (patients served, students educated in prevention concepts, etc.).

This system will provide for the Director visibility of all Institute program activities. The following will be provided:

-- An Overall Management Information and Control System

The Overall Management Information and Control System will provide for the Director and key staff a total programmatic and functional picture of the entire Institute for decision-making and control. This includes a brief description of the functional programs in each Division, its workload of applications, grants and contracts, in-house studies, manpower anf fund allocations. It will be a coordinated and condensed overview of the supporting Detailed Management Information and Feedback Control Systems.

-- A Detailed Management Information and Control System by Functional Programs

The Detailed Management Information System will provide information on each functional program in each Division, Office of by other staff. The status of the workload, progress and number of staff assigned to each program will be available, and the effectiveness evaluated by results achieved.

-- A Feedback Control System

Feedback control information will be provided to and for the Director and key staff for decision-making: (1) on the functional scope of applications received in each Division/Office to avoid overconcentration of efforts and of expenditures in any one program area and region prior to award of grants or contracts to assure a balanced effort and workload; (2) on the functional programmatic know-how of type of grants and contracts being awarded in any area to provide for improved interfacing and interaction between programs; (3) on manpower allocation by functional programs; and (4) on effectiveness of each type of program in the communities for consideration of changing priorities, for additional support of these types of programs or phase-out whatever applicable.

Annual Report

The Annual Report for Congress for each fiscal year is prepared by Program Coordination in accordance with the requirements of P.L. 91-616, Title I, Section 102, and P.L. 93-282, Section 101. This narrative report for FY 1975 provides a description of the actions taken during the fiscal year and an analysis and evaluation of the effectiveness of all actions, services and expenditures of funds for all programs and functions of the Institute. It will, in the future, also report (as specified in P.L. 93-282, Section 101, dated May 14, 1974) on the extent to which other Federal programs and departments are concerned and dealing effectively with the problems of alcohol abuse and alcoholism. These actions can only be reported after full implementation of the Inter-Agency Committee on Federal Activities for Alcohol Abuse and Alcoholism. This report covering FY 1975 reflects the fourth full year of operations, of the NIAAA. It contained a description of the actions taken, services provided, and funds expended under P.L. 91-616 and Part C of the Community Mental Health Centers Act, and an evaluation of the effectiveness of such actions, services, and expenditures of funds. P.L. 93-282 (May 14, 1974) made the Institute a part of ADAMHA, one of the six agencies reporting directly to the Assistant Secretary for Health.

National Environmental Policy Act (NEPA) P.L. 91-190 Implementation

The National Environmental Policy Act (NEPA) of 1969, P.L. 91-190, Executive Order 11514, Guidelines of the Council on Environmental Quality (CEQ), require the assessment of the environmental impact of all Federal and Federally supported programs and projects before a decision to take the action and the commitment of resources and a reassessment of ongoing programs.

Implementation Actions:

(a) Generic Analysis

The implementation of the DHEW Compliance Procedures, Chapters 30-10 to 16 of October 1973, is in process. The Office of Program Coordination has performed a Generic Analysis of each type of the NIAAA's programs and projects to identify those programs and classes of actions that can be screened out (exempted) as they do not have a significant impact on the environment and these programs are not subject to the NEPA requirements of assessing each application, grant, contract and ongoing program. A Statement of Inapplicability (SI) could then be provided and these programs would only have to be reviewed if they fall under the exception of the SI. As of December 31, 1975, NIAAA has not been exempted and, as a result of more detailed information provided to the reviewing panel and a better understanding of the programs of the Institute, a new review of the Generic Analysis is now in process by the principal environmental compliance officer for DHEW, Office of Environmental Affairs (Office of the Secretary for Administration and Management), in conjunction with EPA and CEQ.

(b) Narrative Information Guidelines for Applicants and Grantees

In accordance with DHEW procedures, narrative information questions have been prepared for the applicants' environmental analysis for each of the applicants. Based on their analysis, NIAAA will perform the environmental assessments for all actions to determine for each individual case whether a Determination of Inapplicability (DI) can be furnished or if a Marginal Impact Statement (MIS) or a Full Environmental Impact Statement (EIS) has to be prepared, which includes also requirements that necessary safequards have to be taken by the applicants and/or grantees to assure compliance with the Act. Should exemption be granted for any classes of programs, assessments will only have to be made for the non-excempted classes of actions.

Privacy Act (P.L. 93-579) Implementation

The Privacy Act became effective September 27, 1975. This Act decreed that: (1) personal information about individuals collected by Federal agencies must be limited to that which is legally authorized and necessary; (2) such information must be maintained in a manner which precludes unwarranted intrusions upon individual privacy; and (3) a subject individual has the right to ask if records about him are in existence, to review such records and to challenge the contents, and have them amended.

To carry out the implementation of this Act, all systems of grants, contracts or studies had to be reviewed during FY 1975 and those types of grants and contracts containing personal data identifying information on individuals or information that can be retrieved by personal identifiers had to be published in the Federal Register and its purpose, the type of information collected, analyzed or evaluated, and other related information stated.

To carry out the intent of this Act, Systems Managers for Grants and Contracts were appointed and a Privacy Act Officer for the Institute in the Office of Program Coordination, to provide safeguards, monitorship, and coordination with all points of clearance, and to assure the privacy of any individual affects.

All contracts in effect prior to the effective date of the Act have been reviewed and, as applicable, have to be amended before June 30, 1976, as the contractors are considered an extension of the government agency. All new contracts involving new systems are undergoing stringent analysis and evaluation and are requiring systems notices, clearances, and advance notice to Congress and the Office of Management and Budget of any proposal to establish or alter any system of records in order to permit an evaluation of the probable or potential effect of such proposal on the privacy and other personal rights of individuals or the disclosure of information.

Any changes in systems of grants in categories of uses effecting individuals have been reviewed and are in process of being published in the Federal Register..

Monthly reports have been prepared by the Institute System Managers and the Privacy Act Officer of any inquiries pertaining to access requests, amendments made, employee training activities undertaken, problems and issues, and annual summary reports are required for high authorities such as the President, the Speaker of the House, and President of the Senate.

Rural Health Initiative Program

A. Integrated Program through Joint Efforts of the Rural Health Coordinating Committee (RHCC)

Objectives:

The objective of the Rural Health demonstration initiative is to design, implement and evaluate integrated health delivery systems to solve the problems of inadequate and inaccessible health services provided in rural areas. The emphasis will be upon integrated multi-program efforts directed at entire populations in county and multi-county areas. In order for these systems to become viable, professionally and economically, the mandate of this effort is to provide comprehensive primary care locally and appropriate linkages will have to be developed to other levels of care including alcoholism treatment services through the interfacing of NIAAA's grantees.

This program is spearheaded by the Office of the Secretary of Health and a PHS Rural Health Coordinating Committee (RHCC), chaired by HSA--National Health Service Corps (NHSC).

The Office of Program Coordination is the designee and coordinator for NIAAA and is participating and coordinating this effort between the Institute, ADAMHA, the PHS Committee, and other agencies as required, and is participating in this effort with the PHS and ADAMHA working committees.

Several models for RHI sites have been proposed by the Rural Health Coordinating Committee (RHCC) and NIAAA has also proposed a model tailored for alcoholic patients as an integral part of the Rural Health care delivery system. Basically, although the models are flexible, the criteria will be the optimum utilization and integration of the resources.

A list of potential applicants of each of the 10 regions has been provided by NIAAA to the RHCC Central Office. The final selection and funding will be provided by the RHCC Central Office with recommendations from the regions and NIAAA. At least 10 NIAAA grantees or potential grantees are planned to receive grants through the RHCC, if the applicants are selected. A grant will range from $50,000 to a maximum of $200,000.

Emphasis is on developing formal relationships by NIAAA (during FY 1976) with the model rural referral centers and consultation networks established between the 10 rural primary care projects and the alcoholism programs serving those areas. The plan is eventually to tie in alcoholism programs with the 47 RHI programs awarded in FY 1975, and the planned additional 70 RHI programs in FY 1976.

B. Rural Health Initiative Program for Health Underserved Rural Areas (HURA)

An additional Rural Health Program called Health Underserved Rural Area Program (HURA) is being coordinated by the Office of Program Coordination. This program is spearheaded by the Social Rehabilitation Service, Medical Services Administration (SRS/MSA). Although this program is also linked to the RHI program described in "A". above, it will be funded by SRS/MSA.

The HURA program is interested in those existing health care providers or organizations which have demonstrated financial viability. HURA will support those organizations with limited funds for expansion.

A HURA grant will not exceed $200,000 for the first year and should show decrease in a three-year period. (This funding will be provided from HURA to any of our grantees.) At the end of a three-year period, the grantee will no longer require HURA monies but move toward self-sufficiency.

The initial phases of the program have been started at the end of FY 1975, the application and selections will be made in FY 1976. Program Coordination will interact and interface with the operating Division, SRS/MSA, and the Central Rural Health Coordinating Committee.

Collaboration and Interaction with Other Agencies

The adequacy and technical soundness of joint or interfacing programs which relate to alcoholism and alcohol abuse were evaluated. Communication and exchange of information and participation was provided to maintain the coordination and effectiveness of such programs and activities. Inter-agency efforts dealing with alcohol abuse and alcoholism were coordinated with related health, rehabilitation, highway safety, law enforcement, welfare programs, and other interested government agencies. These formal and informal inter-agency agreements provided for the collaborative utilization of each agency's resources as appropriate.

Inter-agency activities in FY 1975 included:

-- Department of Transportation (DOT) Public Education Campaign

A national public service program was coordinated and implemented by NIAAA with the Department of Transportation's National Highway Traffic Safety Administration (NHTSA) to increase public awareness of the facts about alcohol use and abuse, to develop responsible attitudes toward the drinking of alcoholic beverages, and to reduce drunk driving. During FY 1975, the monitorship of this agreement was performed in conjunction with NHTSA. The agreement and funding took place in FY 1974. DOT reimbursed NIAAA in FY 1974 $642,209 of a total of $1,391,287 expended by NIAAA for the Public Service Education Campaign.

-- Department of Transportation Alcohol Safety Action Programs (ASAP)

The joint effort by NIAAA and the National Highway Traffic Safety Administration, of the Department of Transportation, to reduce traffic accidents caused by drinking drivers continued through FY 1975. The drinking driver program was conducted as a collaborative relationship with the Department of Transportation in 10 selected geographical alcoholism program safety areas. NIAAA provided technical support, consultation in the setting up of ASAP's service programs and referring drinking drivers to treatment facilities. The inter-agency effort helped to reduce the number of drinking drivers on the road through the treatment process.

-- Department of Justice - Joint Planning for Criminal Justice Population

NIAAA staff was represented on an advisory board of the Department of Justice to oversee the planning of two items: (1) the development of model treatment programs for the criminal justice population, and (2) the planning for a joint symposium to bring together the State Planning Agencies and the State Drug Authorities to discuss strategies for the delivery of drug abuse treatment to the criminal justice population, with input on alcohol abuse and alcoholism where applicable. The symposium will take place in FY 1976. The cost of the symposium will be borne by National Institute on Drug Abuse (NIDA), and advice and technical assistance will be provided by NIAAA.

-- Department of Justice - Development of Guidelines for the Drug Abuse and Alcoholism Programs for the Criminal Justice Population

In March of 1975, the Law Enforcement Assistance Administration (LEAA) issued the guidelines to the State Planning Agencies for drug abuse and alcoholism treatment programs for the criminal justice population. During FY 1974 and 1975, coordination and consultation was provided on establishing LEAA guidelines to State Planning Agencies on alcohol abuse treatment programs for the criminal justice population mandated by P.L. 93-83. NIAAA participated in a task force to accomplish this effort.

-- Legislative Professional Staff Project on Drug Abuse and Alcoholism by the National Citizens Conference on State Legislatures Supported by the National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and National Highway Safety Administration (NHTSA) of the Department of Transportation (DOT)

In FY 1975, the multi-year inter-agency agreement, which was awarded in FY 1974, was implemented and coordinated among the National Institute on Drug Abuse (NIDA), NIAAA, and the National Highway Traffic Safety Administration (NHTSA), for the National Citizens Conference on State Legislatures (NCCSL). The major objectives of the program are: (1) to stimulate state legislative action in developing sound policies dealing with drug abuse and alcoholism; (2) to demonstrate that the efficiency and effectiveness of the legislative process is substantially improved if major standing committees operate on a year-round basis with the support of full-time, professionally qualified staff; and (3) to build communication linkages between state legislatures, Federal agencies, and the educational and scientific communities.

This program is designed to demonstrate the value of support by professionally qualified staff and to evaluate the impact of such staff on State legislative action relating to alcoholism and drug abuse. NCCSL teams of well-trained and experienced staff were placed in selected demonstration States to assist appropriate committees over a two-year legislative cycle. The knowledge gained will be disseminated to key legislators of non-demonstration States through seminars and conferences. The total program effort (to extend through FY 1978) will amount to $2,313,353, of which NIDA will reimburse NIAAA $675,000. During FY 1974, NIDA reimbursed NIAAA $390,000 for its effort during FY 1974-1976 and DOT, NHTSA, reimbursed NIAAA $100,000 in FY 1974 for participation in the grant award to the Citizens Conference on State Legislatures for State Legislative Action on Alcoholism and Drug Abuse. In FY 1974, NIAAA and NIDA awarded the Citizens Conference on State Legislatures a grant amounting to $982,050 for direct costs for FY 1974 through FY 1976. During FY 1975, staff (10 professionals) was employed and trained to implement the actions described in (1) through (3) above in five demonstration states. The five demonstration states are: Pennsylvania, Oklahoma, Oregon, Wisconsin, and Virginia. It is planned that the results of the five demonstration states will be shared with legislative bodies in the surrounding states early in FY 1976. This will be accomplished through seminars.

-- Department of Defense - Alcohol Programs Activity

Programs, formal and informal agreements, were coordinated with the Department of the Navy, Department of the Army, and Department of the Air Force, under which NIAAA provided consultation services and support in the creation, implementation and evaluation of their programs. Besides technical assistance and consultation, materials were prepared for specific target groups.

Department of the Navy - A presentation was prepared for their Navy Alcohol Safety Action Program to support their Alcoholism Prevention Program. NIAAA will be reimbursed $6,400 for this effort. A brochure was prepared by NIAAA explaining the Chaplain's role in the Navy Alcoholism Prevention Program. NIAAA will be reimbursed $8,975 for this effort.

Also, an evaluation of the Department of the Navy's treatment program for alcoholism was conducted at treatment centers (dry docks) by NIAAA staff (Division of Prevention). The findings were submitted to the Department of the Navy.

-- National Bureau of Standards - Development of Standards for Occupational Alcohol Abuse Programs

Consultation was provided to the National Bureau of Standards in the development of policies and procedures for alcohol abuse programs designed to serve Bureau personnel in the metropolitan Washington, D.C. area.

-- Department of State

Consultation was provided to assist the Department of State in establishing a program for the prevention and treatment of alcoholism for State Department personnel stationed in foreign countries.

-- Civil Service Commission

Consultation is currently being provided to the Civil Service Commission to set up occupational alcoholism programs in 10 Civil Service regions.

-- National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA)

A joint program monitoring service between NIDA and NIAAA is being carried out at 10 cites which are demonstrating the provision of combined treatment services for alcohol and drug abusers.

-- Administration on Aging, Office of the Assistant Secretary for Human Development, Office of the Secretary

Preliminary negotiations have been started with staff of the Administration on Aging (AOA) to explore mutual interestes in joint program development for the aged person experiencing problems with alcohol.

-- Indian Health Service - NIAAA

Continued collaborative relationships between NIAAA and the Indian Health Service exploring avenues of joint programming and exchanging ideas on the development of alcoholism services for American Indian people were carried out.

-- Health Services Administration - NIAAA

A liaison and consultant relationship has been maintained through FY 1975 with the Division of Emergency Medical Care Services, Health Services Administration (HSA), for the purpose of sharing information and program materials that will assist both the alcoholism field and the general emergency medical care programs in developing emergency care services for alcoholic persons.

-- Law Enforcement Assistance Administration - NIAAA

NIAAA has continued a relationship with the Law Enforcement Assistance Administration (LEAA) in reference to the criminal offender who suffers from alcoholism. NIAAA has collaborated with LEAA in stimulating the development of program materials to aid both alcoholism and criminal justice administrators in program development for this population.

-- Social Security Administration (SSA) and NIAAA - Information Exchange Pertaining to NIAAA Grantees Involved in Alcoholism Treatment

The Social Security Administration and NIAAA exchanged data in FY 1975 relating to the implementation of Title XVI of the Social Security Act, as amended by P.L. 92-603 (Section 1611(e)(3) of the new Supplemental Security Income program), which requires that an alcoholic person be undergoing active treatment to be eligible for such assistance.

Evaluation of treatment efforts, relating to implementation of Title XVI, were begun and have continued through FY 1975. (Technical support was provided by an Institute physician and other professional staff.)

-- Department of Transportation, Federal Railroad Administration, and NIAAA

During FY 1975, NIAAA maintained a major effort with the Federal Railroad Administration by serving on their task force for the purpose of assessing the need for alcoholism policies and/or regulations covering railroad personnel.

PUBLIC AFFAIRS

During FY 1975, the Institute's Public Affairs program continued to encompass a wide range of efforts designed to increase public awareness of the facts about alcohol use and abuse and to develop and disseminate public information materials to enable the general public to make responsible decisions about the use or nonuse of alcoholic beverages.

Functions performed were in the following areas:

-- Collection, dissemination and coordination of public information

-- Public awareness information campaign

-- Media contacts

-- Preparation and clearance of publications

-- Support services

Public Service Education Campaign

NIAAA's nationwide public awareness campaign entered its third full year with the development of additional radio and television public service announcements. The radio materials included several of the most effective information pieces used in the previous year. To help electronic broadcasters, NIAAA developed a "Handbook" in both English and Spanish. The "Handbook" provided broadcasters editorial materials on the myths and facts about alcohol use and abuse and ideas for local programming. For television, NIAAA produced 13 public awareness spots, including several in Spanish.

Also during FY 1975, the radio series "All About Alcohol" answered the most asked questions sent in by the general public. The series was used by approximately 3500 radio stations. This included the armed forces radio service.

Media Contacts

A major responsibility of Public Affairs was to coordinate speaking engagements, newspaper and magazine interviews, and appearances on radio and television for the Institute Director and senior staff members. Fiscal year 1975 saw an ongoing program of media contact as part of the Institute's overall effort to raise the public awareness level of alcoholism problems. Because of the excellent quality of materials made available to both radio and television during this fiscal year, NIAAA received a large share of the highly competitive public service time made available by the electronic media to non-profit organizations.

Through the coordinated efforts by Public Affairs, the Institute's role in the Nation's alcohol problem was given high visibility in such major publications as Time, U.S. News and World Report, New York Times, Los Angeles Times, and Chicago Sun-Times.

There has been an increase in alcohol use among youth and alcohol use among women over the past year. The Office of Public Affairs responded to approximately 100 requests a week from reporters of all media. They were interested in NIAAA thrusts, policies and general statistics.

Publications

One of the major functions of Public Affairs has been its role in the preparation of publications to better respond to the ever-increasing interest in alcoholism by professionals and the general public. While much of this responsibility was shifted to the Division of Prevention during FY 1975, Public Affairs did provide coordination of many publications of the Institute.

Support Services

An essential responsibility of Public Affairs was to provide professional communications and information services for the staff of NIAAA.

Public Affairs gave programmatic and technical advice to the Division of Prevention and the Office of Education in the production of the series of films for Junior and Senior High School alcohol curricula.

Technical Assistance

Public Affairs supported a three-year grant awarded in FY 1974 to the National Council on Alcoholism in the amount of $1,549,035, of which $569,110 was expended in FY 1975, to act on the community level as advocate, initiator, catalyst, and provider of technical assistance in mobilizing local-level volunteer groups nationwide for improved alcoholism information, dissemination of localized alcholism education, and existing public service and prevention materials. In addition, technical assistance was provided to the National Council on Alcoholism-Alaska Region (NCA-AR) on a program funded in FY 1974 in the amount of $1,500,000 for a period of two and one-half years to support a public education and information campaign.

During FY 1975, monitorship was performed of a contract in conjunction with the Department of Transportation's National Highway Traffic Safety Administration (NHTSA), for a nationwide alcohol abuse and alcoholism public service campaign to raise the level of the public's awareness of the potential dangers of alcohol abuse. The contract amounted to $1,391,287, of which DOT reimbursed NIAAA in FY 1974 in the amount of $642,209.

Public Affairs also provided technical assistance to the National Center for Alcohol Education (NCAE) and to NIAAA division-level activities.

NATIONAL ADVISORY COUNCIL ON ALCOHOL ABUSE AND ALCOHOLISM

MANDATE

During FY 1975, the National Advisory Council on Alcohol Abuse and Alcoholism continued to provide consultation, advice, recommendations, and other assistance to the Secretary of Health, Education, and Welfare, and to the Administrator, Alcohol, Drug Abuse, and Mental Health Administration, regarding the policies and programs of the Department in the area of alcohol abuse and alcoholism. The Council made recommendations to the Secretary regarding program priorities and emphasis, as well as regarding effective policies and procedures for the coordination of activities in alcohol-related programs of various agencies within the Department. Council also reviewed and made recommendations on applications for grants relating to prevention, training, research, and provision of treatment and services in the field of alcohol abuse and alcoholism.

ACCOMPLISHMENTS

The Council's major contributions have been the provision of consistently high level scientific review and evaluation of research, training, prevention, community assistance, occupational and special project grant requests submitted for Federal support.

In FY 1975, Council reviewed a total of 1,146 applications requesting funds in the amount of $71,773,957. Of these 1,146 applications, 508 applications requesting a total of $70,237,856 were recommended for approval in the amount of $61,437,382--and 499 applications amounting to $93,758,902 were recommended for disapproval. One hundred and thirty-seven applications requesting a total of $22,431,029 were deferred.

During FY 1975, Council made significant contributions toward the review of policy and issues related to the functions of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), including:

-- The National Advisory Council encouraged the revision of the Federal Criminal Code to explicitly provide that alcoholism is a defense to prosecution under Federal law to the same extent, and under the same conditions as any other illness considered in the Code. Such legislation would substitute appropriate treatment and rehabilitation under civil law, instead of punishment under the criminal law.

-- The Council strongly urged the Secretary, Department of Health, Education, and Welfare to assign a minimum of 16,000 square feet of space and 8 clinical beds, at the NIH Campus, to the Intramural Program of NIAAA.

-- Council endorsed the Institute's request for increased funding for research and increased positions for the intramural program, and requested that the Administrator, ADAMHA review options available to him to provide clinical and laboratory space for the alcohol program on the NIH campus.

- Council passed a resolution regarding the National Center for Alcohol Education--as to the possible continuance or discontinuance of the Center. They agreed to continue efforts toward developing and pursuing some alternative to keep viable those aspects of the Center which are positive and important.

- Endorsement of a motion that travel ceiling be raised to $350,000 without increasing the total Institute budget for 1975.

- Council approved the Trans Alaskan Oil Pipeline Grant Application that has two major components: (1) the community alcoholism program for communities effected by population impact, and (2) an occupational alcoholism program for construction workers on the line. The grant was approved with a number of conditions, including continued involvement by the Governor's Advisory Board on Alcoholism, the State Alcoholism Authority, and assurances from the Anchorage Community College that training will be provided to program personnel.

Council has offered, and continues to offer, innovative suggestions for the establishment and development of program direction with the NIAAA, particularly in the areas of research and prevention.

INTERNATIONAL ACTIVITIES

Through international cooperation, the nations of the world are provided with an opportunity to use a variety of resources to consider common concerns in the area of alcoholism treatment and research. Toward this end, the NIAAA funded a variety of studies to stimulate and support multi-national cooperation in undertaking basic and applied research concerning the causes of the most effective methods of combatting alcohol abuse and alcoholism. In addition to a number of ongoing studies, several new projects were begun in FY 1975.

International Grants:

Effects of Ethanol on Amino Acid Metabolism. Sir Hans Krebs, Oxford University, England, 12/1/73 - 11/30/76. This grant to Dr. Krebs, a Nobel Laureate and the Principal Investigator, is in its third year.

The objective of this work is to evaluate influence of ethanol addition upon nitrogen metabolism of perfused rat livers. Mechanism whereby addition of ethanol to the perfusate results in the accumulation of such amino acids as aspartate, glutamine, and glutamate will be ascertained. Influence of ethanol on isolated vivo experiments are proposed to be conducted to determine whether effects observed in isolated perfused livers can be observed in vivo.

Earlier work has shown lysine to accelerate glucose synthesis from lactate and to abolish the inhibition caused by ethanol. Under this grant during the past year, the investigators have made a more complete analysis of the interaction between lysine and ethanol. It has been shown that several other amino acids (including asparagine, ornithine, tyrosine, arginine, alanine, phenylalanine and proline) have similar effects.

Results of work to date lead to the conclusion that the reactions which re-establish redox equilibria take precedence over other reactions such as glucose synthesis. This implies that there is competition for intermediates common to two or more metabolic sequences.

The findings during the past year contribute to the analysis of the manner by which ethanol disrupts liver metabolism and how some of the effects can be counteracted. Publications include a paper on the accumulation of aspartate in the presence of ethanol in rat liver and a report describing a device for the separation of isolated hepatocytes or similar tissue fragments for analysis of cell constituents.

To date this grantee was supported with $62,762, of which $6,200 was awarded in FY 1975.

Epidemiology of Alcoholism in Latin America. Pan American Health Organization (WHO), Dr. Marilynn Katatsky, Washington, D.C., 4/1/72 - 3/31/77.

The objectives of this five-year grant awarded to PAHO are to: (1) study drinking patterns in ten Latin American sites to determine prevalence of alcoholism and heavy drinking in urban, semi-rural, and rural settings relating to type of beverage, age, sex and cultural variables; and (2) establishment of Centers for Studies on Alcoholism.

To date, a pilot Center for Studies of Alcoholism has been established in San Jose, Costa Rica, funded in part through this grant and through the Costa Rican National Institute on Alcoholism. The Center has completed several research projects and has developed a number of other research and prevention efforts. The Center's library is now operational and is providing services to researchers in Costa Rica and other Latin American countries. Endeavors are continuing for development of a similar viable Center in Brazil, and toward this end an agreement has been signed between PAHO and the State of Sao Paulo. In addition, the Education Project has launched a nationwide program in the elementary schools. Data on survey of drinking attitudes and behavior have been collected for six sites and are in process of being analyzed.

Since alcohol abuse and alcoholism are particularly devastating in Central and South America, this grant represents a mutually shared cooperative effort to understand the causes of alcoholism in Latin America and to develop education, prevention and treatment programs.

To date, this grantee was supported with $864,187, of which $165,187 was awarded in FY 1975.

Alcohol & Aldehyde Metabolizing Dehydrogenases. Jean P. von Wartburg, University of Bern, Switzerland, 2/1/74 - 1/31/77. January 1, 1976, commences the third year of this three-year grant.

The objective of the present grant is to conduct detailed studies of isoenzymes of aldehyde dehydrogenase and aldehyde reductase.

Earlier research indicated that some enzymes responsible for metabolism of alcohol do not have the typical form and that it may be under genetic control. This is an extension of Dr. von Wartburg's prior studies of the alcohol dehydrogenase into the investigation of a new inhibitor of the enzyme (Aminorex) and its various substrates. The project also plans to assess biochemically aldehyde dehydrogenase and reductase, primarily in brain, for clues on the local cerebral metabolism of alcohol and its effect on the pathogensis of withdrawal and tolerance to alcohol.

His studies to date appear to support the conclusion that ethanol administration has a profound effect on biogenic amine metabolism at several levels, and this would indicate that certain changes in physiologic functions which result from chronic ethanol ingestion are mediated by the metabolites of the biogenic amines.

Studies under this grant have resulted in the isolation and characterization of four multiple molecular forms of aldehyde reductase from human brain and two forms from rat brain.

A method for the determination of disulfiram and its metabolites in blood of patients treated with this drug has been developed by this investigator which enables an evaluation of the time span for effective medication.

The significance of the work by this investigator is in sorting out probable biochemical mechanisms initiated by alcohol in the nervous system. In addition, the development of diagnostic techniques and tests are of potential significance to clinicians.

To date, this grantee was supported with $134,020, of which $38,040 was awarded in FY 1975.

Prevention of Adverse Metabolic Effects of Alcohol. A. Hugo Theorell, Karolinska Institute, Sweden, 6/7/72 - 5/31/75. Third year of grant has been extended to 4/30/76 and supplemental funds awarded.

The objectives of this work are to find a means of abolishing or eliminating metabolic damage of alcohol consumption by partial inhibition of alcohol combustion, using synthetic inhibitors of liver alcohol dehydrogenase (LADH), and to determine the total three-dimensional structure of LADH by X-Ray crystallography.

The study has been aimed toward improving the basic understanding of how ADH works at the molecular level. It has been found that an inhibitor of LADH, 4-methyl-pyrazole prevents liver damage (fat infiltration) caused by alcoholism in rats. Preliminary experiments indicate that a partial inhibition of ethanol oxidation by 4-methyl-pyrazole counteracts the liver triglyceride accumulation in rat and dog. Further synthetic work has revealed pyrazole derivatives that are much stronger blocking agents than 4-methyl-pyrazole.

A major significance of the work under this grant lies in the more complete understanding of the three-dimensional structure of the ternary complexes of ADH with coenzyme and blocking agents or substrate as a result of the excellent x-ray crystallographic work being done by the investigators.

To date this grantee was supported with $347,789. No additional funds were obligated in FY 1975. Further support is under consideration.

Brain Stimulation and Alcohol Preference. Roy A. Wise, Sir George Williams University, Canada, 5/1/72 - 4/30/75, (completed).

The objective of this project was to identify the neural substrates underlying the phenomena by which electrial stimulation of the lateral hypothalamus elevates normal ethanol intake in rats.

The significance of the work is in developing and analyzing an animal model for human alcoholism, through improved understanding of the neural mechanisms involved in voluntary ethanol intake.

This project was completed April 30, 1975. The grantee was supported with $46,930.

Ethanol-Induced Changes in Brain Mitochondria. S. French, University of British Columbia, Canada, 3/1/72 - 2/28/75 (completed).

The objective of this project was to determine the mechanisms of ethanol depression and ethanol withdrawal hyperactivity of the central nervous system.

The results of this work support the subsensitivity-supersensitivity concept of drug tolerance-dependency. That is, ethanol ingestion causes tolerance and subsensitivity by increasing norepinephrine at the post-synaptic membrane receptor site which causes a decrease in the cyclic AMP response of the brain to NE in vitro.

Over ten journal articles have been published (or in press). Although the work under this grant has been completed, the investigator is conducting further studies on this topic under a new grant (No. AA-02294) awarded to the Veterans Administration Hospital, Martinez, California.

This project was completed August 31, 1975. The grantee was supported with $96,415.

International Research Contracts:

Review of Alcoholic Beverages in the Etiology of Certain Cancers in Man. International Agency for Research on Cancer, World Health Organization, Dr. J. Higginson, Lyon, France, 6/28/75 - 3/31/76.

The objective of this work is to utilize various international sources of data to review the relation of alcohol consumption to certain cancers in man. This involves, more specifically, the following: long-term prospective studies collecting detailed information from individuals; comparison of hospital data with various control groups; examination of the relation between disease states, such as cancer sites or cirrhosis, and aggregate indices of alcohol consumption at region, state, or country levels; exploration of mortality trends over periods of time in which rates of alcohol consumption varied widely, as in France, Finland, and Norway; comparison of special sub-populations, e.g., Copenhagen Brewery workers, with control groups; and analysis of alcoholic beverages to identify and determine the amounts of potential carcinogens present.

In their most recent meeting, the investigators agreed that associations, with different degrees of certainty, exist between alcohol and cancers of certain sites, i.e., buccal cavity and pharynx, urinary bladder, stomach, esophagus, colon, rectum, liver, pancreas, and larynx. In addition, certain research principles were enunciated including: (1) use of objectively defined alcohol consumption; (2) joint investigation of other alcohol-related diseases along with cancer, and other possible etiological factors for cancer along with alcohol; and (3) focus of study on those populations that can be defined as to their alcohol intake, that are known to consume one main type of alcoholic beverage, that can be traced adequately in existing mortality or morbidity filing systems, and that can be compared to groups of non-drinkers.

The total amount of this contract is $259,650, of which $158,050 was awarded in FY 1975.

International Working Symposium on Alcoholism Research in Industrialized Countries. International Council on Alcohol and Addictions, Archer Tongue, Lausanne, Switzerland, 6/74 - 6/75.

The objective of this contract was to convene an international working symposium on alcoholism research in industrialized nations to discuss priorities for research, existing treatment services, and communication systems, as well as allocation of resources among the aforementioned.

The Report of the Symposium concluded that the lack of fundamental knowledge in certain areas prevented agreement on definitive answers to some of the issues raised in the agenda. Participants were not prepared to force a solution on priorities. They did, however, identify certain areas where research effort should be further encouraged. These include: (1) the elucidation of biological factors with influence ethanol intake; (2) an investigation of those processes which are involved in habituation and dependence on ethanol; (3) an investigation of certain pathological conditions related to the chronic over-consumption of ethanol in a more selective way than has occurred in the past; (4) epidemiological studies; (5) the evaluation of therapy; (6) a study of the effects of legal and economic changes on alcohol consumption and related problems; (7) a refinement of research instruments and methodology; (8) the clarification of concepts and terminology; (9) the definition of the various types of alcoholism and alcohol abuse; and (10) the identification of treatment goals and criteria for the evaluation of treatment.

This contract was awarded in FY 1974 in the amount of $27,190. No additional funds were awarded in FY 1975.

Criteria for Identifying and Classifying Disabilities Related to Consumption of Alcohol. World Health Organization, Dr. T.A. Lambo, Geneva, Switzerland, 5/74 - 12/75.

The objective of this contract was to develop methodology and conduct a study to formulate international criteria for detecting and classifying disabilities related to alcohol consumption.

The approach that was developed and forms the basis of the WHO Report emphasizes the concept of alcohol dependence as a diagnosable condition of great importance; it rejects the notion that alcohol dependence is some sort of monolithic and all-or-none condition with only one presentation whatever the culture; it emphasizes the importance attached to analysis of alcohol-related disability itself; it emphasizes the need to recognize that not all alcohol-related disability is alcohol-dependence related; it discards the notion of "problem drinker" as a category of any certain meaning; and it emphasizes the importance of interacting personal and environmental factors.

The total amount of this contract was $40,500, of which $10,000 was awarded in FY 1975.

NATIONAL INSTITUTES OF HEALTH

National Institute of Arthritis, Metabolism, and Digestive Diseases

Seven years of research grant support by the NIAMDD have yielded proof that severe liver injury can be produced by prolonged alcohol ingestion in the absence of dietary deficiencies. Consequently the Council on Foods and Nutrition of the American Medical Association has commissioned the investigator, Dr. Charles S. Lieber, to summarize his findings in a position paper.

Dr. Lieber's research has culminated in the finding that alcohol exerts direct toxic effects on both the liver and gut, resulting in structural alterations in cells of the intestine, and in successive development of fatty liver, alcoholic hepatitis, and cirrhosis. He warns that alcoholics should not be led to believe that correction or prevention of nutritional deficiency will prevent liver damage in the face of continued alcohol abuse.

Malnutrition, it was found, is common among alcoholics because alcohol displaces protein-, vitamin-, and mineral-containing foods in the diet, and chronic alcohol consumption eventually may result in malabsorption of some essential nutrients. In his early studies, the investigator showed that rats develop a fatty liver when fed ethanol as part of a nutritionally adequate diet; subsequently, he duplicated these findings in monkeys and in normal and alcoholic volunteer human subjects.

His studies have revealed that liver injury is preceded by an adaptive phase characterized by accelerated metabolism of drugs (including ethanol), and ketonemia and hyperlipemia followed by accumulation of fat in liver cells, secondary to hypertrophy and hyperactivity of certain critical intracellular components. Side effects included enhanced liver poisoning by other noxious agents, such as carbon tetrachloride.

Finally, Dr. Lieber has shown that fatty liver produced by ethanol can progress to alcoholic hepatitis and cirrhosis despite a nutritionally adequate diet. Baboons were fed a diet in which ethanol isocalorically replaced carbohydrate and accounted for 50% of the total calories. All 15 animals developed fatty liver within nine months; five exhibited typical alcoholic hepatitis, and five baboons that were studied for two to four years developed cirrhosis.

The Mount Sinai School of Medicine investigator summarized his findings in a special communication to the Journal of the American Medical Association.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

ALCOHOLISM

Over the past several years, people with the primary disability of alcohol abuse have constituted between 4% and 5% of the total number of individuals rehabilitated by State rehabilitation agencies. The Rehabilitation Act of 1973 requires that priority in services be afforded severely handicapped individuals, and neither the Act nor the Federal regulations includes alcoholism within the definition of severe handicap. Therefore, it appears probable that there will be a gradual decline in the number of alcoholic individuals served by State rehabilitation agencies in the future.

Numerous special projects in alcoholism have been conducted by State rehabilitation agencies. In New Jersey, for example, the State agency has worked in close collaboration with private industry and organized labor in identifying and providing necessary services for employees whose jobs are endangered by alcohol abuse. Another project with a similar purpose was operated by the Wisconsin agency at DePaul Rehabilitation Hospital in Milwaukee. The Texas agency administered a project in El Paso to help the Chicano alcoholic, and another project in Dallas County to serve people being treated for alcoholism at Terrell State Hospital. Additional projects designed to serve alcoholic people have been active in Alabama, Alaska, Connecticut, Florida, and Washington.

The Rehabilitation Services Administration has been operating in close cooperation with the National Institute on Alcohol Abuse and Alcoholism. Among their joint activities has been a national conference of the Directors of State alcoholism and State vocational rehabilitation agencies conducted in March 1973 for the purpose of stimulating cooperative planning and programming in the area of alcoholism.

Research and Demonstration projects concerned with alcoholism have (1) developed methods of counseling, placement and follow-up of members of skid row populations; (2) conducted long-term follow-up studies of rehabilitated alcoholics; (3) studied career patterns of alcoholics to identify factors in successful vocational adjustment; (4) established a half-way house for homeless alcoholic men; (5) studied problems of alcoholic offenders; and (6) developed two series of films on rehabilitation of alcoholics based on research results, one intended for public showing over television and the other series for professional training.

Also administered by the Office of Research and Demonstrations is the Special Foreign Currency Program. Evaluation and reports on progressive action programs in Poland and Yugoslavia are of value to the United States and other countries where there is concern about the increasing number of alcoholics and problem drinkers. There is a greater recognition by programmers in this field that these men and women need social and psychological rehabilitation services. New projects emphasize an interdisciplinary approach to ascertain the most efficient methods of bringing about vocational rehabilitation in a community setting for alcoholic and problem drinkers. This program will be closely integrated with the domestic rehabilitation research program.

Number of Alcoholism Rehabilitations

Fiscal Year	Persons Rehabilitated Total	Alcoholics
1973	360,726	16,452
1974	361,138	14,800
1975	324,039	14,600
1976	334,200*	14,800
1977	353,000*	14,800

*Estimated

Public Services Administration

Alcoholics

The Public Services Administration has responsibility for administering the Social Services program authorized under Titles I, IV-A, X, XIV, XVI and XX of the Social Security Act, as amended. Except for Guam, Puerto Rico and the Virgin Islands, Title XX superseded all of the authorizing titles cited above as of October 1, 1975.

Under Title XX, grants are made to States for services to eligible individuals based on income or public assistance status. States may choose the services they will provide, as long as each service conforms to at least one of the five goals stated in the Act.

Within the broad spectrum of services provided to eligible individuals are those directed to preventing, solving or alleviating the problems brought on by alcoholism. It is estimated that States will spend $43,200,000 in Federal funds through the Social Services program in F.Y. 1977 for services related to alcoholism.

Estimate Cost for Programs Serving American Indians

(Dollars in Thousands)

	1975	1976	1977
Health			
Indian Health:			
Direct Care	87,628	102,954	110,490
Contract care	45,848	51,110	59,732
Field health services	102,060	126,535	54,603
Construction	59,160	57,509	40,345
Program management	3,060	3,450	3,554
Subtotal	297,756	341,558	268,724
Other Health Services			
Health manpower	3,128	3,120	1,603
Alcoholism and general mental health	1,478	1,465	1,584
Total, Health	302,362	346,143	271,911
Office of Education			
Elementary and secondary education	50,851	46,972	44,542
Indian education	42,034	57,055	42,055
School assistance in federally affected areas	46,500	63,225	66,755
Emergency school aid	3,974	3,974	3,983
Education for the Handicapped	1,221	1,312	1,346
Occupationa, vocational and adult education	10,597	8,228	7,742
Higher education	25,951	29,702	23,237
Library resources	1,313	780	530
Total, Education Division	182,441	211,248	190,190
Office of Human Development			
Child development	12,250	12,250	12,250
Native American programs	32,000	32,000	32,000
Rehabilitation services	4,866	5,004	5,004
Total, OHD	49,116	49,254	49,254
Total, HEW	533,919	606,645	511,355

HEALTH SERVICES ADMINISTRATION

The Indian Health Service

The Indian Health Service (IHS is a component of the Department of Health, Education, and Welfare's Health Services Administration (HSA), which is working to improve health services and promote better health for all Americans. The responsibility of the Indian Health Service is to 463,000 American Indians belonging to more than 250 tribes and 55,000 Natives living in 300 Alaska villages.

The problems that these citizens encounter in preserving health and obtaining needed health care exceed those of most other Americans. The goal of the Indian Health Service is to raise the health of the Indian and Alaska Native people to the highest possible level and assist them in every way possible to achieve a better quality of life. Interacting with other HSA activities in many mutually beneficial ways, and with public and private agencies, the Indian Health Service is developing innovative ways to dispense health services, utilize manpower, stimulate consumer participation and apply resources. In this effort, the Indian Health Service has three major objectives:

> To assist Indian tribes in developing their capacity to man and manage their programs through activities such as health management training, technical assistance, and human resource development and provide every opportunity for tribes to assume administrative authority through contracts and delegation.
>
> To act as the Indians' and Alaska Natives' advocate in the health field to generate other interests and resources which can be utilized.
>
> To deliver the best possible comprehensive health services, including hospital and ambulatory medical care, preventive and rehabilitative services, and to develop or improve community and individual water and sanitation facilities and other environmental factors affecting good health.

ORGANIZATION OF THE SERVICES

Headquarters - The staff of the Indian Health Service headquarters includes health and administrative professionals and clerical staff who support overall operations and provide advice and guidance to field offices. The organizational structure and activities of the staff are geared to serve as a resource for field staff personnel in management, administrative services and various health disciplines.

Field Administration - The field service is divided administratively into eight area offices, and three program operations. Each area and program office is responsible for operating the health program within its designated geographical area, utilizing Indian Health Service or contract facilities, to provide comprehensive health care services.

Service Units - Areas are broken down into service units, to facilitate operation of the program. A service unit is the basic health organization in the Indian Health Service program, just as a county or city health department is the basic health organization in a State health department. These are defined areas, usually centered around a single Federal Reservation in the Continental United States, or a population concentration in Alaska. A few units cover a number of small reservations; some large reservations are divided into a number of units. The Navajo Reservation, which covers 24,000 square miles in three States and has a service population of approximately 99,000 is divided into eight service units. Most service units encompass a hospital or health center, staffed by competent teams.

Research and Training - The Office of Research and Development in Tucson, Arizona, combines the Service's Training and Health Program Systems Centers, and the Papago Reservation health programs. There, new methods and techniques for health care delivery, reporting systems, and manpower resources and utilization are being developed to provide new insights into the improvement of health care planning, programming, and implementation and evaluation.

THE IHS COMPREHENSIVE HEALTH PROGRAM

The comprehensive health services program is designed to cope with the observed and stated health needs of Indian people and Alaska Natives. It provides a broad scope of primary care and preventive and rehabilitative services, through a system of expanding facilities, manpower, and health programs. Planning and implementation of all phases of the health services program reflect the cooperative efforts of a highly proficient health and administrative professional staff and consumer representation of the Indian people and Alaska Natives. Tribal health boards, advisory boards, community development activities, Indian training and manpower recruitment programs, local health activities have all helped to assure consumer input. These activities and others provided through tribal contracts provide the resources to enable Indians to man and manage their own program.

In recent years a number of private, State and other Federal governmental health resources have been mobilized to assist Indian Health Service in its mission to improve the health status of Indian people and Alaska Natives. These include programs of other constituencies of the Department of Health, Education, and Welfare, the Department of Housing and Urban Development, the Office of Economic Opportunity, the Bureau of Indian Affairs, the Department of Labor, and the National Council on Indian Opportunity; with a number of States; with individual Indian tribes and intertribal groups; and with private and voluntary Indian interest groups.

FACILITIES AND SERVICES

The program is carried out through a system of 51 hospitals, ranging in size from 5 to 183 beds, 3 of which are referral, teaching and research centers, 99 health centers, including 27 school health centers, and more than 300 health stations and satellite field health clinics. Additional medical and dental clinics are held at appointed locations on a regular schedule, daily, weekly, or monthly. Special clinics are held intermittently, as needed. Contracts are also maintained with over 300 private or community hospitals, more than 18 State and local health departments, and some 1,600 physicians, dentists and other health specialists to provide hospitalization, and specialized diagnostic and therapeutic services. The contract program is used in locations where there is no Indian Health Service facility, health professional, or alternate resource to provide the required service.

Most service units have a hospital or health center, and a number of satellite clinics, providing inpatient care and outpatient services through preventive and curative clinics. Special services include prenatal, postnatal, well-baby, family planning, diabetes, heart disease, trachoma, tuberculosis and immunization programs. Added services are provided by public health nurses, community health medics (physician assistants), tribally employed community health representatives, nutritionists, health educators, mental health workers, social workers and sanitarians who are engaged in home visits, in follow-ups on discharged tuberculosis patients and newborns and mothers, in health education conferences and in environmental health endeavors.

School health programs are conducted in boarding and day schools operated by the Bureau of Indian Affairs, Department of the Interior, and public schools on reservations.

Dental Services are provided at hospitals, health centers and health stations, and in mobile dental units. In some locations where the Public Health Service has no facilities, care is provided under contract with dentists in private practice. In Alaska, dental teams travel to remote villages by charter plane taking equipment with them.

Dental care for persons under 17 years of age is given priority, a policy that began in 1968 when the DMF rate (decayed, missing and filled teeth) for Indian children showed a decline for the first time in 13 years. Expanded resources, increased efficiency and the addition of dental assistants, have contributed to a steadily decreasing DMF rate since then. Reaching all children and providing care for an increasing number of adults are continuing aims.

Environmental health services provided under the direction of Indian Health Service sanitarians are an integral part of the Indian Health Service total comprehensive health program. In concert with the health staff, the sanitarian works to combat unhealthy environmental conditions and practices, poor and crowded housing, lack of safe water supplies and inadequate waste disposal facilities, all of which contribute to a high rate of infectious diseases.

NEW DIRECTIONS

Consumer Involvement - The increasing involvement of Indian people, especially in leadership roles, has been one of the most significant developments in recent years. A Division of Indian Community Development has been established to make the Indian Health Service more responsive to the health needs of Indian people and their changing role in managing their own health programs.

The National Inter-Tribal Health Board of 12 Indian leaders representing all areas and program offices, Indian health boards and other committees, are helping to develop policy, determine health needs, establish priorities and allocate resources at each administrative level throughout the Indian Health Service. In addition to health programs, social, economic and other aspects of better health and quality of life are being emphasized. Existing problems are being identified and new ideas, resources and health related programs are being developed to bear upon the problems of health services delivery. The involvement and subsequent contributions of Indian groups have led to changes in health services delivery methods and more effective adaptations of health services in a number of Indian Health Service locations.

NEW COMMUNITY INITIATIVE

Indian and Alaska Native people have taken the initiative to develop and operate a variety of local programs to meet their critical needs. Many individuals have taken leadership training in health affairs which they are utilizing in their respective reservations and communities. The effectiveness of local action has been demonstrated in direct community health services activities such as programs in nutrition, accident prevention, alcoholism control, suicide prevention, mental health, improved housing and other areas of community action and economic development.

Indian self-determination is rapidly emerging as a working concept. It is uniquely evident in California and the Southeastern United States where Indians are managing their own health affairs.

The California Rural Indian Health Board, under agreement with the Indian Health Service, is arranging the delivery of a variety of health services to Indians living in 16 project areas composed of 34 counties. The United Southeastern Tribes Intertribal Council is managing health care for Indians residing in Mississippi, North Carolina, Florida and Louisiana, through Indian Health Service and contract facilities in those states.

The Indian Health Service has geared up to implement the new Indian Self-Determination Act (P.L. 93-638) that became effective November 1975. This Act permits the tribes within the P.L. 93-638 regulations to assume control of the program serving them and operate them through contracts or grants with the Federal Government.

SPECIAL PROGRAMS

The level of health today among Indians and Alaska Natives is in many respects similar to that of the general population about a generation ago. Physicians encounter a greater variety of clinical conditions in Indian Health Service facilities than in other health programs in the country. Special health needs are met in varied ways with activities keyed to removing the source of the problem.

MENTAL HEALTH

As the Indian peoples have been caught more and more in the conflict between their old, traditional culture and the demands of modern American society, mental health problems have increased. The seriousness of mental health problems among Indians and Alaska

Natives is demonstrated in age adjusted suicide rates which are 1.8 times as high as that of all races, and a homicide rate 3.0 times as high. Indian deaths from alcoholism, alcoholic psychosis, or cirrhosis with alcoholism are 6.2 times as high as in the general poulation.

Emotional problems and behavioral disorders are frequent among Indian children in their struggle for identity and achievement of self-sufficiency in a new social set-up. There is increasing need for the development of new and effective methods to prevent further trauma to the growing child.

As of this fiscal year, professional mental health teams are working in all Indian Health Service areas, a full functioning inpatient mental health program is operational for 4 years at Gallup, Indian mental health workers are performing a major part of mental health services to their respective communities, and numerous projects in alcoholism control are developed and operated by Indian communities.

OTITIS MEDIA

Otitis media has always been a serious health problem among Indians and Alaska Natives, and in the last decade, has replaced tuberculosis as a major health problem, inflicting serious and often permanent damage.

The extreme prevalence of the disease, with the accompanying demands for prolonged treatment, curative and restorative surgery and rehabilitation created a workload that was impossible to meet out of regular program resources. In 1970 Congress appropriated additional funds especially for an otitis media program, making it possible for Indian Health Service to institute the kind of program necessary to bring this serious problem under control.

NUTRITION

In spite of improvement in the quantity and nutritional quality of their available food supply, substantial numbers of Indians and Alaska Natives still do not have sufficient food and/or food of high nutritional quality to prevent or overcome the relatively common evidence of mild or moderately severe nutritional problems occurring among the population. This is particularly significant for those at highest nutritional risk; infants, preschool children, prenatals, females in the childbearing years of 15-44, the elderly and the chronically ill. Lack of understanding of the relationship of food to health continues to be widespread.

Poor nutritional status may be associated with prematurity, retarded physical growth and development, underweight as well as obesity, a high incidence of infectious disease (particularly gastroenteric and respiratory), chronic disease and injury, unfavorable intellectural and emotional development, and poor performance during pregnancy.

Proper nutrition will contribute to the prevention of prematurity in infants. There also is growing evidence that the adequacy of nutrition during fetal life and early infancy may affect intellectual and behavorial development as well as physical growth and development.

MATERNAL AND CHILD CARE

The high rate of illness and death among infants in the first year of life is met with emphasis on early prenatal care for the mother and continuing care after she and the baby leave the hospital. Health education activities are conducted to teach the mother proper ways to feed, bathe and care for her family within the often limited resources of her home, how to recognize illness, and why it is important to observe good health habits and make regular visits to the clinic.

A nurse midwife program was recently introduced to reach mothers living in isolated areas. The first such program was initiated in Alaska in 1970 to expand and improve the health care of mothers and children, and to demonstrate the role a nurse midwife can play in reducing maternal and infant deaths. Similar programs have since been instituted in Shiprock, and Gallup, New Mexico, and in the Fort Defiance, Tuba City, Keams Canyon and Chinle Service Units in Arizona, in Pine Ridge, and Rosebud, South Dakota, Lawton, Oklahoma, and Anchorage, Alaska, in cooperation with the Schools of Nursing, University of Utah and Johns Hopkins University.

Public Health Nursing has been actively involved in growth and development counseling, and close follow-up/supervision of high-risk mothers and infants, both directly and through other community workers.

AGING

The Indian Health Service is responsible for the administration of a health program which provides comprehensive health services to approximately 518,000 Indians and Alaska Natives. Based upon the age distribution of the 1970 U.S. Census, approximately 6 percent of this population are persons age 65 and over, and about 13 percent are 45 to 65 years of age. Thus Indians and Alaska Natives are a young segment of the U.S. population.

The aging and aged persons within the purview of the Indian Health Service are reached through its program focus upon the family constellation and upon Indian and Alaska Native communities. The health and health related services provided, covering the life span of this population, have resulted in a decline of 17 percent in the crude death rate for Indians and Alaska Natives in the reservation States between 1955 and 1974. In 1960 the life expectancy of the Indian and Alaska Native was 61.7 years, and in 1970 it was 65.1 years, as compared with the U.S. all races total of 69.7 and 70.9 for those same years.

To more readily advance the health status of the Indian and Alaska Native people, and to assist this population group in the exercise of their rights as citizens, Federal and State services as available to all other citizens are utilized along with Indian Health Service health care programs. Those services available from other resources for the aged are coordinated with the IHS program to help meet the needs of the individual aged Indian and Alaska Native.

Professional Preparation - Indian Health Training Program: The Indian Health Service continues to support physician residency training in pediatrics through out-of-Service programs. Such training includes instruction in prevention, diagnosis, treatment and rehabilitation of mental retardation.

The Indian Health Service continues to provide both in-Service and out-of-Service training for nursing and auxiliary personnel, including community workers (CHR's), to ensure continuity of service from hospital to homes.

The Indian Health Service continues to develop and use coordinated teaching guides for hospital and public health nursing personnel, designed as aides in teaching good health practices to maternity patients and their families.

Preventive Services - Prevention of Organically-Based Mental Retardation: The best prevention of organically-based mental retardation is an active, comprehensive, high quality program of prenatal, intrapartum and postnatal care for mothers and infants. The Indian Health Service continues to put high priority on its total services for mothers, infants and children by encouraging more and better prenatal care, better nutrition, full use of family planning services and counseling. Deliveries are provided at 47 hospitals, and outpatient pre- and post-natal care and counseling are available at all facilities.

Better nutrition of pregnant mothers, and of their infants, reduces organically-based mental retardation in infants; as does more complete prenatal care which allows earlier detection and correction of medical conditions which can harm the unborn infant.

Genetic counseling is provided when indicated, and to promote responsible parenthood family planning services are provided. These services include assistance with problems of infertility as well as with the more common problem of spacing pregnancies.

The Indian Health Service also continues its efforts to increase the number of infants and children immunized against measles and rubella, to reduce the number of children with brain damage and congenital anomalies that result from measles encephalitis and from maternal rubella during the first trimester of pregnancy.

The Nurse-Midwifery program continues to increase the services available for better care of mothers and children.

Services for mentally retarded patients are coordinated with state and local health departments by Area Offices and Headquarters, Indian Health Service. Assistance and cooperation of Regional Offices, through grant-in-aid funds, makes possible regional planning of programs and services for the mentally retarded.

Preventive Services - Prevention of Functionally-Based Mental Retardation: As part of the ongoing comprehensive health program on Indian reservations, the Indian Health Service is working cooperatively with Headstart programs and Bureau of Indian Affairs schools and personnel in all Areas in efforts at prevention, detection, treatment and planning rehabilitation for children with functional mental retardation. The model dorm program jointly sponsored by Indian Health Service and Bureau of Indian Affairs continues as a successful mechanism in preventing functional mental retardation in early school age children.

ALCOHOLISM

Special Approach for the Indian Population: In 1969 an Indian Health Service Task Force on Alcoholism stated that "the majority of suicides, murders, accidental deaths, and injuries are associated with excessive drinking, as are many cases of infections, cirrhosis, and malnutrition. By far, the majority of arrests, fines, and imprisonments are the result of drinking (76 percent)." As a part of the President's message to the American Indians in July 1970, additional dollars were committed to begin development of needed special programs. With the development of the National Institute on Alcohol Abuse and Alcoholism in FY 1972, the OEO funded projects totalling $1.2 million were transferred to NIAAA in FY 1973. At present there are 162 Indian alcoholism programs totalling $16.1 million.

These programs have as objectives: to increase understanding and awareness of the problem; to change community attitudes; support rehabilitation sources; to develop preventive programs for Indian youth; and, design education and training programs in the field of Indian alcoholism. The Institute's projects are designed to provide residential care, individual counseling, job placement, referral service, group therapy, Indian AA groups, recreation and self-government. The essential aspect of these projects, however, is the integration of Indian cultural patterns into the rehabilitative and learning processes by hiring Indian staff for programs, working through individual tribal mores, and emphasizing the Indian's image of himself.

The problem of alcohol abuse and alcoholism among Indian people requires excellent technical assistance in developing Indian alcoholism programs, training for Indian people, research into psycho-social variables of alcohol abuse and alcoholism among Indian people and sufficient funding, in order to deal effectively with this major health problem. The Indian Health Service and the NIAAA are in agreement on this approach together with the Indian community whose input helps clarify what the objectives should be, and who will assist in setting national policy with respect to the delivery of more effective alcoholism services to the American Indian and Alaskan Native communities.

CENTER FOR DISEASE CONTROL

Preventive health services

Venereal Disease Services to Indians

The American Indians, Eskimos, and Aleuts receive venereal disease control services through VD project grants awarded to State and local health departments by the Federal Government. Approximately one-half of the 800,000 Indians living in the United States are eligible for health services provided through the Indian Health Service facilities located in 24 States. The State health department and the individual Indian Health Service facilities jointly coordinate the VD control efforts and services in each State.

In late FY 1972, as the national gonorrhea control program was being implemented, CDC staff visited each of eight Indian Health Service Area Directors with representatives of the concerned State and local health departments. These meetings established the agreements necessary for supporting the extension of venereal disease control services in Indian Health Service facilities. Primarily, the resources in support of program expansion have been provided through State health departments, as supplemented with Federal grants, with the Indian Health Service providing clinical services.

Gonorrhea culture screening and follow-up services are established and functioning well at most Indian Health Service medical facilities. The number of women screened has continued to increase each year since the program was formally initiated during FY 1973:

	Screened	Positive	
	(No.)	(No.)	(%)
FY 1973	38,443	2,405	6.3
FY 1974	49,274	2,427	4.9
FY 1975	58,892	2,825	4.8

In addition to screening activities, syphilis and gonorrhea casefinding services are provided to infected individuals in an effort to interrupt the transmission of disease. Systems also exist to ensure that individuals with reactive serologic tests for syphilis receive adequate medical attention.

Among Indian populations the VD control program in the Navajo Area is the most complex in terms of the level of disease incidence and the coordination effort required. The program involves four States and three DHEW Regions. Resources for the control program in the Navajo Area are furnished by the States of Arizona and New Mexico, supplemented with Federal grants. In addition to these resource inputs, the Indian Health Service has a contract with the Navajo Tribal Council to furnish outreach services in support of the VD control program.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH

National Institute on Drug Abuse

The National Institute on Drug Abuse (NIDA) has become increasingly committed to alleviating the problem of drug abuse among American Indians, and in both FY 1976 and FY 1977 will support over 25 projects in this area at a funding level of $1,500,000. NIDA's initiatives have expanded during the past three years from the support of treatment projects to more recent efforts in training, demonstration, and research. At the same time, NIDA has attempted to insure that a coordinated approach be maintained by consulting with Federal agencies already involved with relevant services to Indians as well as with various Indian associations themselves. This method has been formalized by the establishment of a collaborative consultant group composed of individuals representing such agencies and organizations as the Indian Health Service, the National Tribal Chairman's Association, and the National Indian Board on Alcoholism and Drug Abuse. The FY 1977 budget will allow NIDA to continue this program at a level of effort consistent with FY 1976.

Treatment Services Programs

NIDA currently supports fourteen treatment projects in which Indians are provided assistance in dealing with their drug abuse problems. A grant with Red Lake Tribal Council in Red Lake, Minnesota provides services exclusively to members of the tribe at a total annual Federal cost of approximately $200,000 with a treatment capacity for 150 patients. This outpatient drug free program provides the following additional services: (a) individual and group counseling; (b) remedial education; (c) preventive services with families and school groups; (d) job training and placement; and (3) cultural and recreational programs. The program also operates four drug awareness centers for teenagers. A second program in Flagstaff, Arizona has four major Indian clinic affiliates including the Apache Guidance Clinic and the Navajo County Guidance Clinic. Services available through this program include crisis intervention, detoxification, inpatient and aftercare as well as family, individual and group therapeutic services. These clinics are supported at a Federal cost of about $110,000 for 60 patients.

Demonstration Programs

Demonstration projects seek to identify the nature and extent of drug abuse among different Indian populations and to develop appropriate treatment modalities. The Institute currently supports five Indian demonstration projects and a technical assistance and data analyst contract with the United States Indian Health Service. The following issues pertaining to the delivery of drug abuse services to Native Indians are addressed:

1. What are the socio/cultural factors that must be considered in delivering drug abuser services to urban and rural Indian communities? What is the community impact of drug abuse programs in Indian Communities?

2. In recognizing the unique relationship of Indian peoples to the Federal Government, what are the special political considerations that must be taken into account in delivering drug abuse services to Indian groups?

3. How does NIDA drug abuse programming interface with existing social and health service delivery systems in Indian Communities?

The following are specific examples of three demonstration activities:

Concho Indian School, Concho, Oklahoma

The Cheyenne and Arapaho Tribes of Oklahoma are conducting a three year demonstration treatment program for young Indian inhalant abusers residing in the Concho Indian Boarding School. The study population includes 256 youth, in grades one through eight, primarily from western and central Oklahoma. The study is focused on social and psychological characteristics, factors contributing to inhalant abuse, and the implementation of a treatment plan based on the premise that finding alternative ways to meet the basic emotional needs of the children will reduce the incidence of inhalant abuse.

Six Sandoval Indian Pueblos, Inc., Bernalillo, New Mexico

This project is funded to demonstrate that a program uniquely fitted to Indian needs and oriented to cultural factors will reduce the incidence of drug abuse by attacking the problems of the individual, family and community which are thought to lead to drug abuse and other forms of self-destructive behavior. Prescriptive programs suited to the individual client will be the principal means. Treatment is contracted to the Gate-La Llave Drug Rehabilitation Program in Albuquerque, but aftercare and follow-up is the responsibility of the applicant. The project is expected to result in a policy to be submitted to the Tribal Government for their adoption and implementation.

Seminole Tribe of Florida, Hollywood, Florida

This is an outpatient program for Seminole Indians residing on three Seminole reservations in Florida. The clients treated include both sexes in an age range of 11 to 75 years who are involved in the use of one or more mind altering substances other than alcohol. The grantee estimates that the number of potential subjects in the program will be 200 to 500.

The treatment component utilizes three differing modalities; i.e., Indian medicine men, peer "therapists", and adult counselors. The length of treatment varies with the modality: (1) Indian Medicine - five to eight treatments; (2) peer therapiest - six months to one year; and (3) adult counselors - six months to one year.

Prevention Programs

NIDA drug abuse prevention programs attempt to promote education, peer interaction, alternative pursuits, counseling, and early intervention activities to inhibit or reduce impairment resulting from the abuse by Indians of natural and synthetic substances (drugs). The following prevention project summaries typify Institute efforts to prevent further drug abuse among Indians:

Small Tribes Organization of Western Washington

This grant project seeks to provide drug abuse information education to the twenty-two tribes of the Small Tribes Organization of Western Washington (STOWW) and develop alternatives to drug abuse by providing prevention activities. Self-awareness groups are encouraged to instill more pride in being native American. The STOWW program maintains that drug abuse is a symptom rather than a cause, and advocates the development of healthy, wholesome attitudes and feelings of positive self-regard for the prevention of drug misuse.

Navajo Drug Abuse Education Program

The Navajo Drug Abuse Education Program (NDAEP) attempts to minimize the abuse of drugs through education. With a staff of seven and an area of 25,000 square miles to cover, the drug abuse workers serve as messengers to convey and expose all aspects of drugs to various groups (e.g., teachers, hospital employees, businessmen, students, etc.) with the intent that these "enlightened" individuals will, in their personal settings and functions (e.g., as parents, teachers, classmates) provide counsel when circumstances are appropriate. NDAEP contends that drug abuse is a major problem in the United States and that the Navajo Indian Reservation, due to its size and population, will experience more serious problems of drug availability and abuse if proper education is not offered when the problem is still small as compared to the alcohol problem on the Reservation.

Alcohol, Drug Abuse, and Mental Health Administration
National Institute on Drug Abuse

Obligations for Programs on American Indians

1972	1973 Actual	1974 Actual	1975 Actual	1976 Estimate	1977 Estimate
Not Available	$486,000	$1,639,000	$1,478,000	$1,465,000	$1,584,000

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH

National Institute on Mental Health

The American Indian has been characterized as the most impoverished and deprived group in our nation, in terms of employment, income, education, health and housing.

In contrast to a slow growth rate of 13% of the American population in the past decade, the American Indian population grew by 50% in the 1960's. The 1970 Census reported 827,000 American Indian and Alaskan Natives in the U.S. The Census reported that in comparison to 14% of all American families, 40% of American Indian families live on income levels below the poverty level. The median age of the American Indian in 1970 was 20 -- eight years younger than the national median. Almost 50% of American Indians are living in urban areas.

Along with the many other statistical indices of the severe plight of the American Indian, indicators of extreme and increasing psychological and emotional distress are present. The suicide rate for American Indian adolescents is four times that of the general population, with a rate 20 times the national average on at least one reservation. The 1973 overall U.S. crude suicide rate was 12.0 per 100,000 in contrast to the American Indian overall crude rate of 19.4 per 100,000. Other indicators of the significant mental health need are the extraordinary incidence of alcoholism, glue sniffing and school drop-outs.

There is a clearly documented need for mental health services especially designed to meet the unique requirements of the American Indian populations. The resolution of this problem is made difficult by a severe shortage of American Indian mental health professionals. There are, for example, only seven known American Indian psychiatrists.

Research

In November 1972 the NIMH Center for Minority Group Mental Health Programs, assembled, at a National Conference on Indian Mental Health, a representative group of American Indians concerned with mental health issues. A major concern expressed by this group was the need for research designed and implemented by American Indians which is directly related to American Indian mental health problems. In direct response to the stated need, NIMH provided funds in FY 1975 to the National Tribal Chairmen's Association and the University of Oregon to establish a National Mental Health Research and Development Center for American Indians and Alaskan Natives. The principal objectives of the Center include:

1. Conduct research which has been identified as a high priority by American Indians, Alaskan Natives, mental health/behavioral and social science scholars, and the Center's National Advisory Committee;
2. Provision of a research preceptorship for American Indians and Alaskan Natives with guidance and supervision by members of the same racial groups;

3. Monitoring and coordination of research projects relating to American Indians/Alaskan Natives, (i.e., projects which are being conducted by other institutions, agencies and programs);

4. Affiliation and collaboration with other research programs focused on studies of American Indian/Alaskan Natives;

5. Provision of technical assistance to American Indians/Alaskan Natives in the design of research and/or identification of resources for support. Upon request, technical assistance would be provided to non-American Indians/Alaskan Natives in the design, evaluation and implementation of research pertaining to American Indians/Alaskan Natives;

6. Collection, storage, retrieval and dissemination of unique mental health and social science data pertaining to American Indians/Alaskan Natives;

7. Identification of model mental health research and development resources and programs relating to delivery of mental health services, manpower development and research for American Indian/Alaskan Natives;

8. Through the Center's National Advisory Committee, Board of Directors of the National Tribal Chairmen's Association, and other American Indian/Alaskan Native organizations and individuals, identification of needs and periodic evaluation of the programmatic directions of the Center.

Priority research areas will include development of culturally sensitive models for the delivery of mental health services to American Indians/Alaskan Natives; identification of factors in high incidence of emotional disturbances among American Indian children in Indian boarding schools; development of a theoretical model for contrasting and/or evaluating the effectiveness of the medicine men and physicians as practitioners for given conditions in selected socio-cultural contexts; assessment of mental health needs of urban, inner-city and reservation American Indians and Alaskan Natives; foster child placement programs (impact on Native belief and value systems, socialization patterns, and quality of adjustment); and effects of non-Indian testing and counseling programs.

In addition, the NIMH has funded bibliographic research on the American Indian which will design a system for classifying literature concerned with American Indian mental health that will aid the social scientist in locating this most needed information. The researcher will design a classification system to categorize information along three dimensions: a behavioral description, the social context to which the behavior appears (for example, the family), and the tribal populations involved. This system will be tested by reviewing and classifying available literature produced during the past years.

Service Delivery and Manpower Development

By December 1974 the NIMH had made construction and/or staffing grants to community mental health centers which are to serve 60 Indian reservations in 17 states. The 39 centers have all or part of the reservations in their catchment areas. A substantial number of the centers have established full-time satellite offices so services are closer to people's homes. An effort is made, as in the Four Corners Mental Health Center in Utah, to employ Indians on their staffs.

The absence of American Indian mental health workers represents a severe handicap to the effective provision of services to American Indian populations. The NIMH has attempted to bridge this American Indian manpower gap through the funding of special social worker training projects in Arizona, Florida, Oklahoma, Oregon, Texas and Utah. American Indian mental health workers have been trained in: California, Colorado, Minnesota, Montana, New Mexico, New York, North Dakota, Oregon and South Dakota. Also, a unique nurses training project was initiated in North Dakota.

Additionally, the NIMH Center for Minority Group Mental Health Programs has supported five and six year graduate fellowship programs (beginning in 1974), in the Professional Societies. The Institute has expectations that these programs will enhance the quantity and quality of Minority manpower in minority group mental health of which Indians will definitely benefit.

Awards made to Professional Society Programs have developed techniques to assist Universities attract and retain minority students. Services are provided to help trainees cope with stresses related to their minority backgrounds. The programs are sponsored and administered by each of the Professional Societies. Each has formed committees, comprised of their members who are Black, Spanish-Speaking, Asian, and American Indian. These committees work together with each of the Minority Program Directors in the development of Program Policy and planning, recruitment, placement of graduates, and other supportive services to students. Evaluation of the effectiveness of graduate education for minorities is an ongoing function of each of the programs.

In light of a realistic need in health service delivery to minorities, by minorities, the NIMH Minority Center is funding projects to paraprofessionals for interdisciplinary training.

It is expected that these paraprofessionals will have a significant impact on the delivery of services by the very nature of their varied specialties and their minority-oriented experiences.

A few examples are:

The Navajo Mental Health Program in Arizona (6 year ongoing program - estimated cost of $687,000). This project will train Navajo men to become medicine men. The art of healing as practiced by American Indians is being developed and coordinated with the art of healing as practiced by American physicians, especially psychiatrists.

The Colesville Confederated Tribes in Neseplem, Washington, is a multivariate (4 year grant - estimated cost $652,000) study being conducted among Indian students in order to develop a more adequate empirical basis for designing effective educational programs needed to raise the educational and occupational performance of Indian youth.

Pueblo of Laguna Service Center in Laguna, New Mexico (3 year grant - estimated cost $122,000) is a Native American community-based service center whose primary emphasis is service delivery for alcoholism treatment, rehabilitation of drug abusers and mental illness. The Center was established in 1968 by authority of the Tribal Council to provide coordinated alcoholism, mental health and counseling services for the people of Laguna Pueblo. NIMH is providing funds to train thirty-six persons in health service delivery. Some of the trainees are mental health workers and other human services specialists already employed in a paraprofessional capacity.

HEALTH RESOURCES ADMINISTRATION

Programs Benefiting American Indians in the Bureau of Health Resources Development

Health Manpower programs for the specific support and development of American Indians do not exist apart from the overall commitment to improve minority participation in health occupations, health care, and health services delivery. This commitment is expressed through the special provisions for minority assistance contained in the principal health manpower legislative authorities of the Public Health Service Act: Title III, Title VII, and Title VIII.

The authorities which provide for minority assistance seek to achieve these objectives for American Indians (as for other minorities): (1) encourage education institutions to develop and expand educational opportunities for Indians; (2) increase the numbers of Indians in health occupations; (3) provide for the advancement of Indians in health careers; and (4) increase and improve the health services provided to Indian communities.

Health Resources Administration

Bureau of Health Manpower

Obligations for programs in Indian Health

	FY 1973 Amount	FY 1974 Amount	FY 1975 Amount	FY 1976 Amount (Estimate)	FY 1977 Amount (Estimate)
Health Professions					
Special Projects	$45,968	$76,865	--	--	--
NHSC Scholarships	--	--	$350,000	$750,000	$750,000
Nursing					
Special Projects	177,755	189,362	140,746	101,513	116,528
Direct Operations (Contracts)	--	78,609	--	--	--
Allied Health					
Special Projects[1]	19,944	26,973	--	--	--
Special Education Programs					
Manpower Initiatives	--	17,700	337,261	--	--
Physician's Assistants	--	--	6,000	--	--
Area Health Education Centers (AHEC's)	638,123	2,154,979	844,044	1,432,724	--
Special Hlth Career Opport. Grts (SHCOG's)	824,177	2,238,752	1,032,158	650,000	556,000
OHRO Contracts	--	72,000	189,747	175,000	175,000
Interagency Transfers to Indian Health Service[2]					
Dental Educational Contracts	--	5,000	20,000	10,000	5,000
Special Education Programs	--	300,000	207,600	--	--

[1] Allied Health special projects are phased out in 1976 in favor of a non-categorical health manpower training support program. These amounts represent a continuation of support to New Mexico City University, a school with a high American Indian population.

[2] These funds are used to support those health manpower projects which are administered by the Indian Health Service.

The health manpower minority assistance awards are not categorical grants to the various minority groups. Rather, the awards are made to individuals and individual institutions. As a result, the identification and categorization of minority recipients cannot readily be accomplished for all awards.

Attached is a listing of those health manpower program awards which have been clearly identified as specifically benefiting American Indians. For the years shown, missing data can be attributed to two factors; either the figures are unavailable, or the explicit amounts associated with assistance to American Indians could not be determined.

It must be stated that the amounts shown do not represent all of the health manpower obligations to American Indians, but only those obligations which can be identified as such. Hence, cumulative totals cannot be shown.

ESTIMATES OF OE FUNDS THAT BENEFIT INDIANS OR ARE ATTRACTED BY THE PRESENCE OF INDIANS 1/
(in thousands of dollars)

	1974	1975	1976 Estimate	1977 Estimate
Office of Education				
Elementary and Secondary Education				
1. Grants for disadvantaged (ESEA I)....	$42,288	$43,000	$43,000	$43,000
2. Support and innovation grants:				
(c) Supplementary services (ESEA III)	829	737	500 2/	---
(d) Nutrition and health (ESEA Sec. 808)............................	288	288	288 2/	---
3. Bilingual education (ESEA VII).......	5,176	3,700 3/	--- 3/	--- 3/
4. Right to read (Ed. Amends. VII)......	161	100	---	--- 4/
5. Follow through (Community Services Act, Part B)........................	3,177	2,901	3,084	1,542
6. Drug Abuse Education (DAE Act).......	150	100	100	---
7. Environmental Education (EE Act).....	25	25	---	---
Subtotal.......................	52,094	50,851	46,972	44,542
Indian Education				
1. Payments to Local Educational Agencies for Indian Education (Part A, IEA).........................	25,000	25,000	35,000	25,000
2. Special Projects (Parts B and C, IEA)	15,000	15,000	20,000	15,000
3. Program Administration (GEPA)........	1,265	2,034	2,055	2,055
Subtotal.................... ...	41,265	42,034	57,055	42,055
School Assistance in Federally Affected Areas				
1. Maintenance and Operations (P.L. 874)	30,839	36,000	58,500	63,000
2. Construction (P.L. 815)..............	11,200	10,500	4,725	3,675
Subtotal.......................	42,039	46,500	63,225	66,755
Emergency School Aid				
1. Special projects:				
(a) Bilingual Education project (ESAA, Sec. 708(c))...............	627	2,931 5/	2,931 5/	2,931 5/
(b) Educational television (ESAA, Sec. 713).........................	249	429	429	429
(c) Special Programs and Projects (ESAA, Sec. 708(a), 708(b)(1))...	---	72	72	108

	1974	1975	1976 Estimate	1977 Estimate
Emergency School Aid - continued				
2. State apportionment (ESAA, Sec. 706(a), (b) and Sec. 708(b))....	$ 1,360	$ 542	$ 542	$ 515
Subtotal........................	2,236	3,974	3,974	3,983
Education for the Handicapped				
1. State grant program (EHA-B)..........	240	971	957	971
2. Deaf-blind centers (EHA-C Sec. 622)..	77	35	35	35
3. Specific learning disabilities (EHA-C)	65	---	100	120
4. Regional resource centers (EHA-C)....	53	45	50	50
5. Special education and manpower development (EHA-D)..................	200	170	170	170
Subtotal........................	635	1,221	1,312	1,346
Occupational, Vocational and Adult Education				
1. Basic vocational education grants (VEA-B)............................	4,328	4,328	4,328	4,328
2. Curriculum development (VEA-I).......	229	---	---	---
3. Teacher Corps (EPDA, B-1)............	4,100	4,100	2,300	2,300
4. Other education professions development (EPDA, Parts C, D, E, F, and Sec. 504)........................	4,024	407	---	---
5. Adult education grants to States (AEA)............................	1,070	1,114	1,114	1,114
6. Adult education special projects (AEA, Sec. 309)....................	500	---6/	---6/	---6/
7. Adult education teacher training (AEA Sec. 309)......................	160	---5/	---5/	---5/
8. Ethnic Heritage Studies (ESEA IX)....	211	162	---	---
9. Dropout prevention (ESEA VIII).......	208	---	---2/	---2/
Subtotal........................	14,621	10,597	8,228	7,742

	1974	1975	1976 Estimate	1977 Estimate
Higher Education				
1. Basic opportunity grants (HEA IV-A(1))	$ 2,900	$ 5,800	$ 9,000	$12,000
2. Supplementary educational opportunity grants (HEA IV-A(2))	2,300	2,600	2,600	---
3. Work-study (HEA-C)	1,650	2,550	2,350	2,150
4. Cooperative education (HEA IV-D)	115	85	60	---
5. Subsidized insured loans (HEA IV-B)	3,200	3,800	4,500	---
6. Direct loans (HEA IV-E)	2,000	2,300	2,350	1,050
7. Special programs for the disadvantaged (HEA IV-A(4))	4,211	4,822	4,822	4,137
8. Strengthening developing institutions (HEA III)	3,517	3,853	3,900	3,900
9. University community services	150	141	120	---
Subtotal	20,043	25,951	29,702	23,237
Library Resources				
1. Grants for public libraries (LSCA I)	250	250	250	---
2. School library resources (ESEA II)	395	558	530[4]	530[4]
3. Training and demonstration (HEA II-B)	626	505	---	---
Subtotal	1,271	1,313	780	530
Total, Office of Education	174,204	182,441	211,248	190,190

1/ In some instances, the dollars estimated for Indian education constitute the amount of funds "attracted" by the presence of Indians or Indian lands. The two principal programs in which this situation occurs are ESEA I and P.L. 874. For ESEA I, when the local educational agency receives its funds, it determines (within the limits of the law) how the funds are distributed to the individual schools within the district. Thus, the dollars drawn to that district as a result of the presence of Indians do not necessarily benefit those Indians. For P.L. 874, once the Federal funds are at the district level, those funds must benefit all students within that district equally. In this case, only a percentage of the funds drawn to the district as a result of the presence of Indian lands benefit the Indians.

3/ Because Bilingual grant program is discretionary in nature, figures cannot be accurately determined until after grants have been awarded.

2/ Consolidated under Support and innovation grants program under Title IV, Part C of Public Law 93-380.

4/ Estimated figure unavailable because of reauthorization under new legislation, Title VII of Public Law 93-380.

5/ Bilingual projects included Indian students as participants.

6/ Included under Adult education grants to States.

Elementary and Secondary Education

The overriding objective of the Elementary and Secondary Education Act appropriation is to foster equal educational opportunity through the support of supplementary education services and capacity building activities to increase the ability of State and local education agencies to offer effective and efficient programs. For such purposes, approximately $46,811,000 in ESEA support benefited Indians in fiscal year 1973 and will increase to $52,138,000 in fiscal year 1976.

Pursuant to the legislation, P.L. 93-380, a portion of ESEA Title I funds are transferred directly to the Bureau of Indian Affairs. Such funds are for use in Federal schools either operated by the Bureau or contracted by the Bureau to Indian tribes and financed by the Bureau. Of the approximately 49,500 Indian students in these schools, 32,300 have been identified as Title I assisted students. Additionally, Title I funds reach Indian children enrolled in public schools through the local educational agency. Since fiscal year 1973 and with the exception of fiscal year 1974, Title I allocations for BIA schools have been $17,567,000; the total Title I funding benefiting Indian students ranges from $38,967,000 in fiscal year 1973 to $43,000,000 expected for fiscal year 1977.

The basic strategy of the newly consolidated Educational Innovation and Support grants program, which includes Title III, ESEA, Supplementary educational centers and services and Title VIII, Section 808, Nutrition and Health is to stimulate the dissemination and replication of successful ideas in educational practice. Of the total for the Title III program in fiscal year 1975, approximately $322,601 was transferred to the Bureau of Indian Affairs. Use was made of these monies to support such activities as the establishment and operation of bilingual education programs in early childhood education. Materials and methods relevant to the community are being designed for the purposes of enriching the sensory experiences of Indian children in their preschool years.

Nutrition and health funding is used to support demonstration projects to improve the health and nutrition services available to children from low-income families. In fiscal year 1974, Indian children on the Blackfeet Indian Reservation in Browning, Montana, and Indian children in Rapid City, South Dakota participated in projects funded by this program.

To assist local educational agencies in responding to the special educational needs of children of limited English speaking ability, Title VII of ESEA authorizes the Commissioner to provide financial assistance to encourage the establishment and operation of educational programs using bilingual education practices, techniques, generally integrated into the regular public school curriculum. Activities in Indian bilingual education focused on inservice training of public school teachers to enhance the educational environment of Indian students in a bilingual/bicultural setting and the certification and placement of American Indian teachers in reading and supervisory positions in public schools, thus promoting a system of education of Indians by Indians.

In fiscal year 1974, the total number of Indian participants in Right-to-Read programs was 2,110. Of these, about 70 were under 21 years of age. Using the concepts, data, and strategies of adult basic education programs, Right-to-Read projects conduct reading programs for Indian youth and adults who are functionally illiterate or who have not completed high school training. In addition to developing the communication skills to enable Indians to function in the dominant economic society and assisting Indian adults to take advantage of occupational and vocational training programs, Right-to-Read projects in Indian communities are directed toward assisting adult Indian participants to complete and attain the General Education Development Certificate.

Indian children participating in the Hopi Reservation, Arizona, Follow through project are receiving individualized instruction in language skills, classification and reasoning skills, and perceptual motor development. The program, sponsored by the University of Kansas, is designed for children in grades K-3. The Hopi Reservation project is supported by comprehensive services which include health and dental care, social and psychological services, and nutritional improvement.

Drug Abuse Education Act funds were used for two primary purposes relative to benefiting Indians. Initially, American Indian teams are trained and given technical assistance in two-week live-in programs to prepare them to return to their communities to develop drug abuse prevention programs geared to the specific needs of Indians. Concomitantly, these teams acquire skills needed to catalyze their respective communities in dealing with their particular drug abuse concerns and problems.

Programs conducted under the Environmental Education Act of 1970 demonstrate new approaches in order to assist the development of formal and non-formal environmental education activities at all levels of education. The United Tribes of North Dakota Development Corporation are engaged in research activities into Indian materials and sources. To date, this project has developed Indian-oriented grades K-12. These materials, based on Indian traditions and lifestyles, are intended to be supplementary to the standard social studies curriculum.

Indian Education

The Indian Education Act (P.L. 92-318) enacted in June, 1972, concerns the education of Indian children at the elementary and secondary levels and the training of education personnel to work at these levels, as well as adult education. Part A of the Act authorizes the Commissioner of Education to award formula grants to eligible local educational agencies and Indian schools located on or near reservations which are not LEA's or have not been LEA's for more than three years to be used to supplement existing elementary and secondary school programs for Indian children. While Part B of the Act focuses on the needs of Indian children, and Part C is directed toward adult Indians, both parts are representative of the intent to provide educational models which will be replicable and integrated with the basic educational curriculum for American Indians. Preferance in funding under Parts B and C is given to Indian tribes, institutions and organizations.

In fiscal year 1973, Federal support for the Indian Education Act was $18,000,000; fiscal year 1974 funding was $41,759,000; fiscal year 1975 funding is $42,034,300; while the estimate for Federal support in fiscal year 1976 is $57,055,400 and for fiscal year 1977 $42,055,400.

Under Part A formula grants are provided to local educational agencies to benefit Indian children through the support of bicultural/bilingual basic educational services as well as enrichment activities, including the design on culturally relevant curriculum materials, limited teacher, teacher aide and Parent Committee inservice training, and such supportive services as guidance and counseling. The non-LEA set-aside under Part A, which increased from 5% to 10% in fiscal year 1975, primarily supports projects in curriculum development, bilingual education, and cultural awareness.

Part B of the Act is designed to provide financial assistance for planning, pilot, and demonstration projects as well as for basic services to address those needs that are not presently being met by other State and local programs designed to benefit Indian children. Early childhood education, materials development, Parent Committee training and other locally determined areas such as counseling, tutoring, remedial programs, and recreational activities comprise the major components of the Part B strategy. Additionally, efforts under this part have been undertaken to support the training of teachers, administrators, and ancillary staff: the development of educational programs in "Indian controlled schools," particularly those directed to public school dropouts; and the development of cultural awareness curricula.

School Assistance in Federally Affected Areas

In order to provide urgently needed minimum school facilities, Public Law 81-815 authorizes Federal funding for school districts impacted by Federal activities. Eligibility is determined by the number of children who reside with a parent who either lives or works on Federal property. Indian children were the recipients of $42,039,000 under the SAFA program in fiscal year 1974. $46,500,000 in fiscal year 1975; $63,225,000 in fiscal year 1976 and will receive approximately $66,675,000 in fiscal year 1977. During fiscal year 1977, under the Maintenance and Operations segment of this program, it is anticipated that all those Indian children benefiting will be those residing on Indian lands, and thus Part "A" children. Additionally, sections 14(a) and 14(b) of P.L. 815 specifically target construction assistance to school districts serving children living on Indian lands. Thus the appropriations for fiscal years 1974, 1975 and 1976 carried special language that is again requested for fiscal year 1977 specifically earmarking funds for construction that will benefit Indian children. It is expected that the funds requested will complete one project begun in 1976 and provide for two new projects in school districts serving Indian children.

Emergency School Aid

Obligations under the Emergency School Aid Act, Sections 708(a), 708(b)(1), and 708(c) as well as the State apportionment funds mandated under ESAA, Section 706(a), (b) and Section 708(b) which benefit Indians are designed both to equalize educational opportunities for those Indians involved and to reduce their isolation from the mainstream culture. However, while no ESAA programs benefit exclusively American Indians, and there are no specific set-aside for this group, it is estimated that in fiscal year 1975 the number of American Indian students enrolled in ESAA-funded school districts was 40,000. Activities conducted under ESAA grants awarded to school districts in heavily populated Indian areas included integrated children's television, bilingual education, evaluation, teacher training and staff recruitment, curriculum revision, and minor classroom remodeling. Community program youth activities aimed at improving the Indian student's self-image through cultural studies program were also undertaken with ESAA funding.

Ethnic Heritage Studies were mandated by the Congress in the Education Amendments of 1972 to increase the understanding and appreciation of the Nation's multiethnic society through curriculum materials development, training and dissemination of materials. For example, an ethnic heritage studies program in the Wichita Kansas Public School System is currently developing curriculum materials on the "Heritage of the Plains Indians." Initiated and coordinated through the Mid-American All-Indian Center, Inc., the project is involving a great many groups. Under the project, eight packages of curriculum materials are being developed on the "Heritage of the Plains Indians."

Education for the Handicapped

Most of the Federal aid programs relative to education for the handicapped are authorized by the Education of the Handicapped Act Programs administered under this appropriation are designed to cohere existing strategies and effect changes in educational patterns in the field by initiating demonstration and model programs and by encouraging innovative techniques and practices. Indian received approximately $1,221,000 during the fiscal year 1975; $1,312,000 in fiscal year 1976 and will benefit from $1,346,000 in fiscal year 1977.

Under the State grant program, EHA Part B, handicapped Indians in Sandoval County, New Mexico, are being provided with individual programmed instruction through the use of multi-sensory approaches. The purpose of this and similar projects is to raise the level of achievement of these students to a level comparable to the norm. In general, the intent of this part is to assist States in the initiation, expansion, and improvement of programs for the education of handicapped children at the preschool, elementary, and secondary school levels.

The Deaf-blind centers program, authorized under the EHA, Part C, Section 622, supports appropriate educational and diagnostic services for deaf-blind children. The Los Lumas Hospital and Training School in New Mexico provides deaf-blind children of the Navajo Nation both full-time educational and specialized intensive professional services to Indian children who have visual and hearing impairments. This program reaches approximately 19 children and their parents, covering a four State area.

The Specific Learning Disabilities program seeks to stimulate the funding of model projects and supportive technical assistance, research, and training activities. The pilot program in Cherokee, North Carolina, directed toward the area's Indian population, has been chosen by the Bureau of Indian Affairs as a model for other BIA schools. Here, Indian children with specific learning disabilities are screened and subsequently provided with diagnostic prescriptive services, while staff development and research activities have also been under way with the support of EHA grant money.

Regional Resource Centers have been established to promote the development application of appraisal and educational programming for handicapped children. At the Southwest Regional Resource Center in Salt Lake City, 58 Indian children are being provided with systematic, comprehensive appraisals which results in their receiving appropriate, quality special education services. Such systematic comprehensive appraisals include: referral and screening, individual assessments, and educational programming. Staff development in the area of assessment and educational programming procedures is a major part of the funded efforts.

The Special Education Manpower Development program of the Education for the Handicapped Act provides financial assistance to prepare teachers, supervisors, researchers, and administrators to work either in direct educational service to handicapped children or in preparing other educators who will work with these children. The teacher training project at Window Rock, Arizona, is recruiting approximately thirty third and fourth level students presently enrolled in the Navajo Teacher Education program to complete the requirements for the Bachelor degree on Special Education. Additionally, this project provides inservice training to regular education teachers and administrators to effect attitudinal changes relative to serving handicapped children. The training project at Sinte Gleska College on the Rosebud Reservation in South Dakota is maining fifteen bilingual Indian teacher aides. These aides will receive associate of arts degree in special education. They will provide appropriate measurable educational services to handicapped reservation children, many of whom currently are receiving little or no services. The teacher training project at the University of South Dakota is training ten graduate level Indian special educators. Upon completion of the programs, the teachers will receive an M.A. along with authorization to teach special education.

Vocational Education

To assist States in maintaining and improving programs in vocational education so that training for career vocations is available to individuals who need such training for gainful employment, Part B of the Vocational Education Act authorizes grants to States based on the formula prescribed in the Act. The vocational education reporting system collected data on the number of Indian participants up to fiscal year 1972. During 1973 and 1974 this data was not collected. Starting in 1975, this data was again collected and it is presently being tabulated for publication soon.

Adult Education

The Adult Education program is directed toward the more than 52,500,000 adults in this country, sixteen years of age and older who lack a twelfth grade level of education and provides that up to 20 percent of the funds allocated to each State may be made available for high school equivalency programs. At least 15 percent of

In fiscal year 1975 an estimated 2,400 needy Indians received long-term, low-interest loans under the direct loan program to enable them to pursue their courses of study at institutes of higher learning.

Special programs for the disadvantaged is comprised of the following four components: talent search, designed to encourage qualified youth to enter postsecondary educational programs; upward bound, providing skills and motivation for success in education beyond high school; special services for disadvantaged students, providing remedial and other special services; and educational opportunity centers, assisting residents of low-income target areas in applying to and securing financial aid from institutions of postsecondary education. In fiscal year 1975, about 20,276 Indian students benefited from these programs, receiving average benefits of $266 in special services, $54 in talent search, and $968 in upward bound and $93 in EOC's. Under the talent search program, Indian students who had dropped out of either high school or college were counseled about postsecondary educational opportunities and financial aid in an attempt to encourage these youth to reenter educational programs. Indians identified as having need of specific kinds of support to remain in postsecondary educational study were offered tutoring, counseling, and remedial work in special services for disadvantaged students projects. Upward bound projects directed toward American Indian populations focused on the development of skills for postsecondary education through residential summer programs in conjunction with academic year follow-up activities for those under-achievers who were considered to have potential for postsecondary education. Those Educational Opportunity Centers designed especially for Indian populations served largely as clearinghouses for information concerning financial aid and academic support as well as providing counseling and tutorial services.

The strengthening developing institutions program provides grants on a competitive basis to developing colleges to assist them in strengthening their academic, administrative, and student services programs so that they may participate adequately in the higher education community. While the law does not specify set-asides for Indian institutions, the Education Amendments of 1972 stipulate that the five-year requirement for eligibility can be waived by the Commissioner for institutions located on or near an Indian reservation or a substantial population of Indian and/or other native Americans, as such action will increase higher education for these minority groups, except that such grant expenditures may not exceed 1.4% of the sums appropriated.

The University Community Services program provides allotments to States to help solve community problems through cooperation with postsecondary institutions. In Indian communities, funding under the University Community Services program was mainly used to support the improvement of tribal leadership, especially in policy-making. Specifically, projects were intended to increase skills in dealing with the rights and responsibilities of individual tribal members, the judicial system, and tribal problem projects with approximately 4,800 participants in seven States.

Library Resources

The Federal role in libraries has recently shifted toward encouraging demonstrations of effective library practices and supporting cooperative library services patterns at the local, State, and regional levels.

In fiscal years 1973 and 1974, under the grants to Public Libraries program, nearly 300,000 American Indians in sixteen States received new or improved library services. Almost the same number of Indians will be served in fiscal year 1975 with approximately $250,000 in Federal support under LSCA, Title I. Services are provided both on and off the reservation and include outreach programs as well as a materials collection of Indian culture, bookmobile services and special library services to the blind and physically handicapped. For example, during the current year the Hopi Reservation in Arizona, working with five community libraries, developed and conducted a weekly arts and crafts program for the general public. In fiscal year 1976, the funds available from LSCA I for American Indians will be approximately $135,000. Similar services will be accomplished.

each State's allotment must be used for special demonstration and teacher training activities formerly funded directly by the U.S. Commissioner of Education. The law further authorizes that up to another 20 percent of each State's allotment may be used for the education of adults in institutions. State advisory councils on adult education may be supported and special assistance is to be given to the needs of persons with limited English-speaking ability.

Based on previous reports from the States it is estimated that about 1.65% of the State grant effort in fiscal year 1975 was directed toward adult American Indians as follows:

Participation - 12,375

Expenditures - $1,113,750

The above data is not expected to change significantly in fiscal years 1976 and 1977.

Section 314 of the Adult Education Act provides special programs for the improvement of educational opportunities for adult Indians. However, this portion of the legislation is administered by the Office of Indian Education in OE.

Higher Education

The Bureau of Postsecondary Education administers a variety of assistance programs in which Indians are eligible to participate, although none of these programs is specifically designed to assist Indian students. The Bureau's program dollars benefiting American Indians increased from $15,563,000 in fiscal year 1973 to an estimated $21,593,000 in fiscal year 1976.

While American Indians are known to be eligible and active participants in the Basic Educational Opportunity Grants program, which provided financial assistance according to a uniform scale to assist eligible persons to finance their postsecondary education, data on participation by race is not yet available. Thus, estimates are based on the proportion of Indian students to the entire student population engaging in undergraduate work at colleges, vocational, technical, and proprietary schools. Additionally, Indians were recipients of grant awards under the Supplemental Educational Opportunity Grant program which is intended to enable those postsecondary students of exceptional financial need to continue their education.

The main object of the College Work-study program is to promote the part-time employment of postsecondary students who must earn a part of their educational expenses. Needy Indian students who attended participating higher education institutions were paid wages for work arranged by the institution, either on-campus or off-campus with a nonprofit public service agency. Low interest loans are also available to Indian students under the National Direct Student Loan Program. Such loans are made to eligible needy students by participating institutions of postsecondary education.

Title IV-D of the Higher Education Act supports grants to help higher education institutions plan, establish, expand or carry out cooperative education programs. Among those colleges having received grants was the Navajo Community College, Arizona, for administrator of a cooperative education program. This college also acted as the financial agent for a six-college consortium (all American Indian institutions) to train cooperative education personnel. Currently, no applications have been submitted to the Office of Education from Indian schools for such support.

The guaranteed student loans program, Title IV-B of the Higher Education Act of 1965, as amended, authorizes a program of guaranteed and subsidized loans to help students finance educational costs at eligible postsecondary institutions. Approximately 9,300 Indian students whose adjusted family income was less than $15,000 were eligible for such loans totalling up to $2,000 for the 1973-74 academic year.

Nearly 225,000 American Indian elementary and secondary school children benefited from School Library funding. Services were provided through both the Bureau of Indian Affairs and the State Educational Agencies and were provided on the reservations as well as in other public schools. In fiscal year 1976 this program and NDEA III will provide Indian children with laboratory and special equipment and materials for elementary and secondary school instruction in science, mathematics, and modern foreign languages. It is anticipated that in fiscal year 1977 these programs consolidated under ESEA IV-B will provide approximately $530,000 to American Indian children in programs and services reflective of past efforts.

During fiscal year 1975, twenty-one American Indians participated in Library training program specifically designed to recruit them into the profession to serve the informational needs of Indians. Of these twenty-one, 9 will be receiving A.B. degrees in Library Science, and twelve will receive training at the para-professional level. In addition, approximately 10 American Indians were recruited for participation in the fellowship program.

In the Demonstration program in fiscal year 1974, two projects were specifically designed to serve Indians on reservations. It is estimated that 19,000 Indians on four reservations will be served by these projects. Recipient tribes will be: Arapahoe, Shoshone, Navajo, Sioux, and Mohawk. With a reduction from the fiscal year 1974 appropriation, approximately $205,000 was available in the Library Career Training Program for training American Indians in Library careers and approximately $170,000 funded demonstration projects which benefited Indians in fiscal year 1975.

OFFICE OF HUMAN DEVELOPMENT

Amount Benefiting Indians

Office of Child Development

	FY 1974 Actual	FY 1975 Actual	FY 1976 Revised	FY 1977 Estimate
Office of Child Development	$11,350,000	$12,250,000	$12,250,000	$12,250,000

The Office of Child Development funds Head Start programs to provide comprehensive developmental services to pre-school Indian children and their families. Grants are made directly to individual tribes and tribal groups on reservations. Additional Indian children are served in urban areas where there are Head Start grantees where they have relocated with their families; however, estimates are not available of the amount of Head Start funds benefiting urban Indian children. The Office of Child Development also funds demonstrations of child abuse prevention and treatment approaches which are designed to meet the needs of reservation and urban Indian families. In addition, several other research and demonstration projects have been funded to analyze and demonstrate ways to improve child welfare services to Indian children.

Office of Native American Programs

	FY 1974 Actual	FY 1975 Actual	FY 1976 Revised	FY 1977 Estimate
Office of the Native American Prorams	$30,900,000	$32,000,000	$32,000,000	$32,000,000

The Native American Programs (ONAP) develops innovative approaches for dealing with the special needs of American Indians, Alaskan Natives and Native Hawaiians and provides technical and financial assistance to enable them to move toward economic and social self-sufficiency. Objectives of the ONAP include: (1) strengthening of tribal governments to enable them to effectively manage and utilize resources; (2) support for establishment and operation of urban Indian centers serving Native Americans living off reservations; (3) support of a wide range of services to meet the individual and family needs; (4) funding to encourage self-help and community economic development efforts; and (5) development and implementation of information sharing systems.

Direct funded grantees provide services which are available to over one-half of the approximately one million eligible Native Americans in the United States. The grant program in 37 states includes 275 tribes, groups, Alaskan villages, as well as 59 urban organizations and one Hawaiian organization.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

The prime purpose of the State-Federal vocational rehabilitation program is to provide such services to physically and/or mentally disabled persons as required to render them ready for and placement into gainful occupation. Information regarding rehabilitation services according to race, including Indians, is collected on the Case Service Report, Form RSA-300. The Indians rehabilitated under the vocational rehabilitation program would account for six-tenths of one percent of total rehabilitations. This percentage relative to Indians is used to estimate the dollars indicated below.

	1975	1976	1977
Est. vocational rehabilitation funds directed to Indians	$4,866,000	$5,004,000	$5,004,000

CEREBRAL PALSY

Cerebral palsy is not a specific disease entity. Rather it is a general term covering the loss or impairment of control or coordination over voluntary muscles that results from damage to the developing nervous system before, during, or after birth. During the lifetime of cerebral palsy patients, the forms of the disorder may change or merge. Any of these manifestations may be associated with varying degrees of mental retardation, speech defects and convulsions.

Although cerebral palsy is always the result of damage to the brain's motor control centers, the damage is of a varied and frequently obscure origin. There is no single effective preventive measure, and no cure. However, careful medical care and good nutrition throughout pregnancy can prevent some cerebral palsy. Also, as a result of the development and use of the rubella vaccine and of the Rh immunoglobulin serum, fewer babies may be born today with cerebral palsy than five years ago. Spasticity, the dominant motor handicap in most cases of cerebral palsy, can be treated symptomatically by physical and occupational therapy, and with orthopedic and neurological techniques. Also, new ways are being developed to minimize the effects of cerebral palsy and to compensate for developmental delays.

The United Cerebral Palsy Associations, Inc., a national voluntary health agency, estimates that there are 750,000 persons in the U.S. with cerebral palsy. Each year, 15,000 babies are born with brain damage that causes cerebral palsy.

The Department's research activities in cerebral palsy are centered in the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) of the National Institutes of Health; its rehabilitation activities are the responsibility of the Rehabilitation Services Administration.

Obligations for Programs in Cerebral Palsy

	1973	1974	1975	1976 estimate	1977 estimate
National Institutes of Health:					
National Institute of Neurological and Communicative Disorders and Stroke	$14,944,000	$12,890,000	$15,120,000	$15,154,000	$15,913,000
Office of Human Development					
Rehabilitation Services Administration					
Basic State Grants	3,534,000	3,900,000	4,080,000	4,080,000	4,320,000
Developmental Disabilities Office	---	---	53,625,000	55,625,000	53,625,000
Total	18,478,000	16,790,000	72,825,000	74,859,000	73,858,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological and Communicative Disorders and Stroke

Cerebral palsy is a term covering impairment of motor function due to brain damage during the perinatal period or early infancy. Usually, the disorder shows no clinical evidence of progression.

Types of Cerebral Palsy

Although symptoms vary, two common types of cerebral palsy are the spastic, characterized by tense, contracted muscles, and the athetoid type, characterized by involuntary movements of arms and legs. Cerebral palsy is also categorized as monoplegia, diplegia, triplegia, paraplegia, or hemiplegia, according to which limbs or regions of the body are affected.

Some children show signs of more than one type of cerebral palsy. Associated defects such as seizures and mental retardation may be more disabling than the motor disability itself. Cerebral palsy is often accompanied by the inability to see, hear, speak, or learn as other people do, and psychological or behavioral problems are not uncommon.

Causes of Cerebral Palsy

A number of the causes of cerebral palsy in the perinatal period have been identified, but any brain damaging condition can cause it. Present knowledge does not allow the complete correlation of clinical observations with brain damage. It is known that anoxia--lack or reduction of oxygen--can harm the developing brain, though it is not yet clear whether the lack of oxygen or its secondary effects are directly responsible for the damage. Maternal infection during pregnancy, blood type incompatibility, and metabolic disturbances in the newborn are also factors.

Maternal infection is considered an especially serious threat to the fetal brain, either by interfering with its normal development, as in rubella (German measles) or cytomegalovirus (CMV) infection, or by damaging it later, as in toxoplasmosis, a lesser known parasitic infection.

Brain damage may occur in the newborn period to infants seemingly predisposed to it by such factors as low birth weight or difficulty in adapting to life immediately after birth. Disordered brain function in the premature or low birth weight infant may also be of genetic or embryonic origin, or it may be a consequence of severe nutritional lack during pregnancy.

In later infancy and early childhood, such infectious diseases as meningitis and encephalitis, as well as other neurological disorders account for an appreciable percentage of cerebral palsy cases. Direct trauma from accidents, especially traffic accidents, is an increasingly alarming cause of this condition. Battering (non-accidental injury) is also a factor in a significant proportion of cases.

Management and Treatment of Cerebral Palsy

Attention is directed at assisting the child to achieve his maximum intellectual and physical potential, using specialized techniques for specific defects. Physical therapy, bracing, and at times orthopedic surgery are indicated if the potential for functioning warrants it. Drugs may be effective in reducing tension and in limiting other problems connected with nerve damage. Physical, speech, and hearing therapy by skilled professionals are important features of any program to prepare the cerebral palsied child to succeed in school and in life.

Management and treatment vary with the child's age, the type and severity of involvement, the presence or absence of seizures, and the level of intellectual capacity. Special educational programming depends entirely on the neurologic manifestations of the disorder, and the level of intellectual capacity.

This recent focus on the whole child and his family, including social and educational factors, has helped family adjustment and the child's education and future occupation.

Collaborative Perinatal Project

By far the largest portion of the Institute's research on cerebral palsy is centered within its Collaborative Perinatal Project. The Project began in 1959 as a prospective, multidisciplinary, long-term investigation of 55,000 pregnancies from birth through early childhood. Since then, scientists in 12 participating hospitals have been observing these children, and recording data about them to determine if it is possible to discover the causes of neurological disorders of early life, including cerebral palsy, and then to develop strategies for prevention and intervention.

The data collection phase of the Project was completed in 1974 and the emphasis has now shifted to analyzing and interpreting the information collected and readying the findings for publication. To provide a framework for this effort, a Comprehensive Plan for Analysis and Interpretation of Collaborative Perinatal Project Data was established and is being carried out by a team of researchers in ten primary areas.

As part of this plan, children with cerebral palsy have been identified and classified. Efforts are in progress which will permit the computerized screening of antecedent maternal-obstetrical variables and pediatric variables with regard to their association with these cerebral diagnoses.

The double disability of cerebral palsy and severe mental retardation is being investigated in ninety children so disabled. Four groups of neonatal factors appear especially important to the investigators: (1) small size at birth, (2) difficulty in independent respiration, (3) certain blood factors, and (4) neonatal seizures.

A manuscript has been completed which relates neurological findings at one year with subsequent cerebral palsy diagnosis at age seven, suggesting that children with early mild cerebral palsy often lose their motor deficits by school age, but remain at heightened risk for intellectual subnormality. Useful predictors of status at school age have been identified for this group.

Analyses in four secondary areas of major abnormalities of pregnancy with special relevance to cerebral palsy are in progress. These are toxemia, maternal infection during pregnancy, neonatal hyperbilirubinemia, and anesthesia-analgesia given the mother during labor and delivery.

So far, these analyses have produced associations between adverse pregnancy outcome and large maternal weight losses (more than one pound per week) but not excessive weight gain, and valuable information on the epidemiology of virus infections in relation to abnormal pregnancy outcome through the use of new immunologic techniques.

Viral Research

Damage to the developing nervous system which can result in cerebral palsy is being studied by NINCDS scientists at its laboratories in Bethesda, Maryland, and Institute grantees at medical centers throughout the country.

NINCDS investigators are using experimental animals, tissue culture technique, and histopathological studies to complement the strict serological approach being used on human sera obtained from the Collaborative Perinatal Project. Recently they found that several viruses of human origin or viral vaccines produced for humans cause anomalies in rhesus monkey fetuses.

Work in this area is also being carried out by Institute grantees. Dr. Guy M. McKhann and his colleagues at Johns Hopkins University are studying multiple model infections and describing the evolving disease process. Their recent investigations of age-dependent susceptibility to viral infections indicate that the increasing resistance seen with maturation of the central nervous system is more likely due to changes in the central nervous system cells than to maturation of the immune response. This is an important observation and a step forward in this group's attempts to dissect and separate the various immunological and non-immunological factors involved in the vulnerability of the developing nervous system to viral infection. It is also expected to assist in the development of criteria by which it will be possible to determine retrospectively whether a given malformation is of genetic, viral, or other origin.

Cytomegalovirus (CMV) infection which may be only a mild disorder for the mother is a serious threat to the fetus and infant. This agent has also been called "salivary gland virus" because it is often detected in the salivary glands. Principal findings of congenital infection with CMV are spasticity, cerebral calcification, and seizures.

In a study supported by the United Cerebral Palsy Research and Educational Foundation, Inc., Dr. Thomas H. Weller of Harvard University is seeking more information about CMV to see if a safe and effective vaccine might be developed against it. Dr. Weller, a Nobel Laureate, has played a leading role in basic research which led to the development of the polio vaccine and the rubella vaccine. Dr. Richard T. Johnson, of Johns Hopkins University, another grantee of the UCP, is also conducting research on viral infections during pregnancy with the intent of developing specific vaccines against known or suspected causes of cerebral palsy. Epidemiological studies of perinatal infection, including one conducted by an NINCDS scientist, have shown that about 1 percent of all infants are born infected with CMV. The NINCDS Collaborative Project, with its large number of patients is especially useful in providing the necessary data for this type of investigation.

Anoxia Research

The major responsibility for research on anoxia, considered by many researchers to be the single most important cause of brain damage culminating in cerebral palsy, resides in the NINCDS Laboratory of Perinatal Physiology. Many years ago this laboratory established the rhesus monkey as a model which has been widely utilized to show what can happen when oxygen transport from mother to fetus is totally cut off or interrupted at different intervals.

A recent experimental study indicates that fetal partial anoxia from any cause may be the primary event which sets in motion a vicious cycle of brain swelling which cuts off blood circulation and causes brain tissue to die. These events occurred in the absence of fetal circulatory collapse or of fetal head compression, two factors previously felt to be necessary for brain injury.

These findings are clinically important because they offer the possibility of intervention which could prevent or lessen brain damage. When anoxia occurs, there is a biochemical change in the brain which accelerates the accumulation of lactic acid--an adverse factor--in the blood. Edema follows, but not immediately. There is an interval in which the obstetrician could have the opportunity to alter the level of lactic acid in the blood. It is suggested that this might be aided by withholding food or intravenous glucose from the mother during labor.

Another observation from this laboratory is that maternal psychological stress can produce anoxia during pregnancy or delivery and lead to adverse fetal outcome. It is suggested that stress could be relieved by pharmacological measures or by psychotherapy, thus eliminating or modifying this factor as a potential for brain damage in the fetus.

These studies of anoxia are significant because of their intent to reproduce the neuropathology of human cerebral palsy and then attempt to determine the critical parameters which lead to destruction of the vital function of the fetus when it is deprived of oxygen and to relate these changes to the pattern of brain injury produced.

It is of interest that Dr. Alfred Brann, one of the researchers who participated in these experimental studies, is setting up a clinical research program on cerebral palsy at Emory University, Atlanta, where he will observe in human infants the problems related to decrease of oxygen near the time of birth which he saw produced experimentally in the rhesus monkey.

Other Research

Recent studies by an NINCDS scientist have shown that greater amounts of certain vitamins are required for microbial differentiation than for microbial growth. This observation suggests that an increased amount of certain vitamins may possibly be needed during pregnancy for differentiation within the fetus than are required during adult life. Therapeutic implications include the possibility that adult daily doses of certain vitamins may not be adequate for women during pregnancy.

The NINCDS supports a large program project at Children's Hospital Center in Boston. Among their other studies, Dr. Charles F. Barlow and his co-workers are investigating the development of evoked potentials and analytic techniques for detection of early sensory deficits and the development and application of biofeedback techniques which might be effective in reducing seizures and hyperkinesis.

The use of biofeedback is also being explored at Emory University where another grantee of the NINCDS, Dr. John V. Basmajian, is systematically evaluating its efficacy in overcoming spasticity and related neuromuscular defects of cerebral palsy patients. In previous research, he demonstrated the value of biofeedback in increasing control over voluntary movement in children with athetoid cerebral palsy.

Progress in Prevention of Cerebral Palsy

This is the area in which the greatest progress has been made. There is no cure at present, but considerable knowledge is now in hand to assist in preventing cerebral palsy due to birth injury. Through research conducted, supported, and stimulated by this and other Institutes of the NIH, by the United Cerebral Palsy Research and Educational Foundation, Inc., and by the American Academy for Cerebral Palsy, preventive measures have been developed. As a result, fewer babies may be born today with cerebral palsy than five years ago. In other cases, brain damage has been minimized by early intervention.

It has been estimated by the United Cerebral Palsy Associations, Inc., that the vaccine to immunize against German measles has prevented 25,000 to 30,000 children from being born with the rubella syndrome this year.

Improved perinatal care, progress in eliminating neonatal jaundice and kernicterus through the use of Rh immunoglobulin for the prevention or sensitization to the Rh factor have also cut the toll of cerebral palsy. Other important preventive measures have been the early identification of high risk fetuses and newborns so that appropriate intervention or intensive services can be instituted promptly.

Coordination of Government Research on Cerebral Palsy

Just as no single professional can provide all that is needed for children with cerebral palsy, no one component of Government can respond to such a mandate. Consequently, responsibilities for research and service to children with cerebral palsy cross both departmental and agency lines and require cooperation and coordination at many levels.

Recent developments along these lines include the establishment of the Interagency Panel on Early Childhood Research and Development to facilitate Federal interagency coordination in planning, funding, and analyzing early childhood research and development, including those related to cerebral palsy. The NINCDS is a member of this Panel.

The Institute is also represented on the NIH Coordinating Committee on Low Birth Weight. As noted, low birth weight is one of the factors associated with brain damage resulting in cerebral palsy. Late this year, the National Institute of Child Health and Human Development opened a Special Care Nursery in its Perinatal Center at the NIH Clinical Center. Among the problems being studied there is low birth weight. It is anticipated that clinical research findings from this research will develop new information with special relevance for cerebral palsy.

Additionally, the Director of the NINCDS is an ex officio member of the National Advisory Council of Services and Facilities for the Developmentally Disabled. The Council studies and evaluates programs authorized by the Developmentally Disabled Assistance and Bill of Rights Act (P.L. 94-103) to determine their effectiveness.

The NINCDS also has a long history of cooperation with the United Cerebral Palsy Associations, Inc., and the National Easter Seal Society for Crippled Children and Adults, two voluntary health agencies working in the area of cerebral palsy, and with the American Academy for Cerebral Palsy, the professional society in the field. Cooperative efforts with these organizations include research but also extend to informing and educating both the lay and medical publics about cerebral palsy through publications, workshops, conferences, and symposia.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

CEREBRAL PALSY

The Rehabilitation Act of 1973 requires that the vocational rehabilitation program give priority in the provision of services to people who have the most severe physical or mental handicaps. Rehabilitation of the individual with cerebral palsy will be a priority activity, not only because of the severity of the disability itself, but also because of the broad range of handicapping conditions it presents. In virtually every case, a multidisciplinary approach is essential to the development of an appropriate rehabilitation program for individuals with cerebral palsy. In an effort to expand and intensify rehabilitation services for this disability category, the Rehabilitation Services Administration has utilized several of its grant programs, and some examples of these grant activities are cited below.

A project was supported to operate a special rehabilitation program for severely disabled college students, including those with cerebral palsy, attending the University of California at Berkeley. The grant assisted with the costs of living in a residential unit staffed with professionals to provide the services necessary to maintain the students' health at an optimum level while they were in college. This project was so successful in meeting the needs of these severely disabled students that its activity has now been taken over by the California Department of Rehabilitation as part of its operating program.

In addition to 3 Rehabilitation Research and Training Centers in Mental Retardation (University of Wisconsin RT Center, University of Oregon RT Center, and the Texas Tech RT Center), six Medical Rehabilitation Research and Training Centers are engaged in studies on cerebral palsy. These research projects deal with the measurement of life success in terms of survival, and educational, vocational and marital achievement in CP, self-care in CP, muscle spasticity in CP, and the medical and allied health services needed by the Developmentally Disabled, including the cerebral palsied. In addition, the George Washington University RT Center has involved clients with severe disability due to cerebral palsy in research projects dealing with the development of modern vocational objectives for the severely disabled homebound.

Neurological research is a priority area for RSA support. Neurological research is considered to cover central nervous system and neuromuscular disorders including cerebral palsy, multiple sclerosis and muscular dystrophy. In previous years neurological research was unfocused. Since the resolution of neurological disorder problems through rehabilitation will greatly contribute to the understanding of many other difficulties experienced by the severely disabled, RSA's current R&D strategy is to synthesize our efforts and give this problem area further attention.

In recent years the Rehabilitation Services Administration has supported short-term training courses in such areas as: (1) vocational rehabilitation methods for professional staff of local affiliates of the United Cerebral Palsy Association; (2) rehabilitation counseling techniques with the cerebral palsied client for the State rehabilitation agency counselors; and (3) executive development for administrators of cerebral palsy programs.

Number of Rehabilitants With Cerebral Palsy

Fiscal Years	Persons Rehabilitated	
	Total	Cerebral Palsy
1973	360,726	1,991
1974	361,138	2,000
1975	324,039	1,900
1976	334,200	2,000
1977	353,000	2,200

*Estimated

OFFICE OF HUMAN DEVELOPMENT
Developmental Disabilities Office
Obligations for Cerebral Palsy Activities 1/

Activity	1975	1976	1977
State Grants	$30,875,000	$32,143,000	$33,058,000
Special Projects	18,500,000	19,232,000	16,317,000
University Affiliated Facilities	4,250,000	4,250,000	4,250,000
Total	$53,625,000	$55,625,000	53,625,000

1/ Funds indicated are the appropriation amounts for the three years. No data is available as to specific categories of developmental disabilities.

Under the Developmental Disabilities Act (P.L. 94-103), cerebral palsy is one of four primary disabilities in the law's definition. Because of the nature of cerebral palsy, it often is combined with one or more of the other three conditions -- mental retardation, epilepsy, and autism.

A multi-disciplinary approach is called for in meeting the lifetime conditions and wide array of services needed. Yet, emphasis is not on pathology and the view that disabilities are static. On the contrary, the system followed is the developmental model with the principales of normalization which look upon each person as having different abilities, interests, values, and needs, and that each is capable of development, growth, and learning.

There are basically 16 services included in nine generic programs used in various combinations to support cerebral-palsied persons. Gaps often occur in crucial points in the habilitation process. It is in this area that concepts underlying P.L. 94-103 find their greatest value in developing methods to fill these gaps and also in coordinating the efforts of the different types of agencies which can help cerebral-palsied persons.

The Developmental Disabilities Office (DDP) has funded a number of research projects in cerebral palsy which have ranged from identifying persons with this disability to vocational training.

The project involving the identification of cerebral-palsied persons was conducted by the United Cerebral Palsy Association in Greater Kansas City, Mo., and the work included securing services for the disabled persons.

A one-year project in Maine, carried out by the Mid-State United Cerebral Palsy Associates, demonstrated a model pre-vocational program for severely handicapped persons. The project developed a rehabilitation program for severely handicapped, cerebral-palsied adults with the objective of increasing job potential.

A program in Rockville, Md., is concerned with training cerebral-palsied persons in electro-mechanical assembly, while a project carried out in Edison, N.J., provides work activity for 150 persons who could not hold jobs in competitive employment.

In West Newton, Mass., a one-year project, had a broad objective of increasing the awareness of teachers, rehabilitation personnel consumers, and others to the problems of cerebral-palsied persons.

Research conducted in Harrisburg, Pa., reflected one of DDO's main concerns--deinstitutionalization. This three-year project, also deals with reform of institutional services.

Related to this is a project in Pittsburg, Pa., developing alternatives in living arrangements for developmentally disabled adults.

DDO participated in a system of 40 University Affiliated Facilities which conduct interdisciplinary training of specialized personnel and provide services for persons with cerebral palsy and other developmental disabilities.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON DAY CARE

A REPORT TO THE
HOUSE COMMITTEE ON APPROPRIATIONS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Federal Funds Expended for Day Care
(Dollars in thousands)

	1975	1976	1977
SOCIAL AND REHABILITATION SERVICES:			
Assistance Payments Administration:			
Work Incentives Program	$ 57,405	$ 51,700	$ 47,000
Public Services Administration:			
Social Services	486,718	555,500	595,200
Child Welfare Services	1,967	1,967	1,967
Subtotal	488,685	557,467	597,167
Office of Planning, Research, and Evaluation:			
Research	2,500	2,800	1,500
Subtotal, SRS	548,590	611,967	645,667
OFFICE OF HUMAN DEVELOPMENT:			
Office of Child Development:			
Head Start	1/	1/	1/
Research and Demonstration	3,500	3,500	2,400
Subtotal, OHD	3,500 2/	3,500 2/	2,400 2/
OFFICE OF EDUCATION:			
Vocational Home Economics	1/	1/	1/
Education for the Handicapped	669	705	555
Subtotal, OE	669	705	555
TOTAL	552,759	616,172	648,622

1/ Estimates are not available on the portion of this program's budget supporting day care.

2/ Does not include amounts expended for day care where such service is ancillary to primary purpose of program, i.e. Head Start and Vocational Home Economics.

Report on Day Care

(Fiscal Year 1977)

The Department of Health, Education, and Welfare funds several programs which provide day care services to children of working mothers. These include day care services under the Work Incentive Program (WIN), Social Services Programs, and the Child Welfare programs, all administered by Social and Rehabilitation Services. In addition Head Start, administered by the Office of Child Development in the Office of Human Development, provides care during the day for many children from low-income families. Day care benefits of the Head Start program are ancillary to the major purpose of Head Start, which is the provision of comprehensive developmental services (educational, nutrition, health, social and psychological) to children and their families. The Vocational Home Economics program in the Office of Education also provides day care to many pre-school children as an outgrowth of its main purpose.

The Department of Health, Education, and Welfare also supports research and demonstration efforts to develop knowledge and strategies to assure that DHEW and other day care resources will be most effectively utilized to provide quality day care services meeting the needs of children, families and communities.

SOCIAL AND REHABILITATION SERVICE

Federal Funds Expended for Day Care

	1975	1976	1977
		(in thousands)	
Assistance Payments Administration:			
Work Incentives Program..............................	$57,405	$51,700	$47,000
Public Services Administration:			
Social Services......................................	486,718	555,500	595,200
Child Welfare Services...............................	1,967	1,967	1,967
Subtotal.......................................	488,685	557,467	597,167
Office of Planning, Research, and Evaluation:			
Research and Demonstration...........................	2,500	2,800	1,500
Total, Social and Rehabilitation Service......	548,590	611,967	645,667

SOCIAL AND REHABILITATION SERVICE

WIN Child Care

Assistance Payments Administration

The Work Incentive Program, authorized under Title IV of the Social Security Act, is a State-administered program designed to encourage and assist recipients of Aid to Families with Dependent Children (AFDC) to achieve self support through a program of training, work experience, employment, child care, and other supportive services. The 1971 Amendments to the Social Security Act authorized child care and other supportive services to be provided to all WIN registrants who need such care and services to enable them to accept work or training. State expenditures are matched by federal payments at the rate of 90 percent.

Child care services include full-time and part-time care for children of WIN participants. Child care may be in their own home, in family day care homes, and in day care centers. Of the child care provided in 1975, nearly two-thirds was full-time and one-third part-time. Child care for children in their own homes accounted for 48 percent of the total care provided, while 33 percent received care in family day care homes and 19 percent were cared for in day care centers.

	1975	1976	1977
Federal Funds............	$57,405,000	$51,700,000	$47,000,000
Child years of care provided..............	96,845	85,000	70,000
Total children...........	200,532	176,000	145,000
Total WIN registration...	2,025,663	2,300,000	2,600,000

Public Services Administration

Day Care Services

The Public Services Administration has responsibility for administering the Social Services program authorized under Titles I, IV-A, X, XIV, XVI, and XX of the Social Security Act as amended, as well as the Child Welfare Services program authorized by Title IV-B of the Act. Except for Guam, Puerto Rico, and the Virgin Islands, Title XX superseded all of the above cited authorizing Titles except IV-B effective October 1, 1975.

Under Title XX, grants are made to States for services to eligible individuals based on income or public assistance status. States may choose the services they will provide, as long as each service conforms to at least one of the five goals stated in the Act.

Under Title IV-B, services are available to all children who need them without regard to the economic circumstance of their families.

Within the broad spectrum of services provided under the above Titles are day care services to children and adults. Services may be provided in the individual's own home or outside the home, including care in family day care homes, group day care homes, and day care centers.

Child care services furnished must be suited to the age, special handicaps or other conditions of individual children and selected with the participation of the mother (or other responsible relative) insofar as possible.

State licensing laws and standards must be enforced to assure that child care facilities used by the agency are licensed or approved as meeting the standards of the licensing authority. All out-of-home care must also comply with the Federal Interagency Day Care Requirements.* Prior to July 1, 1977, the Department must submit a report to Congress on the appropriateness of these requirements.

In F.Y. 1977, it is estimated that States will expend $545,200,000 in Federal funds through the Social Services program and $1,967,000 through the Child Welfare Services program to provide an estimated 947,000 recipient months of service.

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* P.L. 94-120 suspended staffing ratios required for children 5 months to 6 years in group day care homes through January 31, 1976. Other pending legislation may further modify these Requirements.

Public Services Administration

Day Care Services (continued)

(In thousands of dollars)

	1974 Actual	1975 Actual	1976 Estimate	1977 Estimate
Social Services day care	$292,200[1]	$486,718	$555,500	$595,200
Child Welfare Services day care	1,841	1,967	1,967	1,967

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[1] This amount, the same as reported in the 1976 Hearings is a preliminary actual. Actual dollars amounted to $387,828,000. (Source: OA-41.7(c) reports) and were projected into 1975-1977.

Office of Planning, Research and Evaluation

Day Care

Following several years of day care demonstration activities, the new R & D program will include those projects continued and approved in FY 1976. One project will demonstrate the effect of in-home-training to AFDC mothers who provide day care. Another will focus on improving the management of day care through improved management systems for information and referral, and an exchange among mothers to provide the best use of day care slots. A third project will study the effect of development assessment of children in day care as well as other siblings in the family. In addition to these projects, a new series will be launched in FY 1976 and will continue through FY 1978. These new projects will include studies on the comparative assessment of regulated and nonregulated child care, comparative cost effectiveness of training and monitoring, assessment of FIDCR impact on agency and providers and consumers, and evaluation of family day care models.

(in thousands of dollars)

1975	1976	1977
$2,500	$2,800	$1,500

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

Day Care

The Office of Child Development (OCD), located within the Office of Human Development serves as an advisor to the Secretary, the Assistant Secretary for Human Development, and other Federal agencies on matters pertaining to the care and development of children.

Child development program efforts aim at improving child care delivery systems and designing programs to improve the quality of life for children and their families throughout the Nation. Major activities are focused on meeting the developmental needs of preschool-age children from low-income families and on improving services to particular populations of vulnerable children such as the abused and neglected, children in foster care, children in need of adoptive homes, and children in institutions. A variety of research and demonstration activities are also conducted. They are designed to improve the quality of children's programs, such as day care and emergency services, and to measure their impact on the children and families served. The three major child development programs are Head Start, Child Welfare, Research and Demonstration, and the Child Abuse and Neglect Prevention and Treatment Program.

Research and Demonstration
(Dollars in thousands)

	FY 1975	1976 Estimate	1977 Estimate
Research and Demonstration (Day Care)	$3,500	$3,500	$2,400

The aims of OCD's day care activities are to develop knowledge and strategies to assist in the effective utilization of Federal, State, local and private resources and in providing quality day care which satisfies the needs of children, their families and their communities.

Current efforts are directed toward: (1) experimental research on a number of key policy issues revolving around the cost of center-based day care; (2) reviewing and evaluating the results of a demonstration project on home-based care with a view toward developing and disseminating information to be used by various kinds of administering agencies interested in creating a network of quality family day care homes; (3) working with state and local licensing agencies in their review and improvement of local licensing codes and regulations using OCD's "Guides for Day Care Licensing" as a basis for this review; (4) initiating a parent survey using replicable survey instruments in order to provide some information about trade-offs parents are willing to make in choosing various kinds of day care; and (5) developing and disseminating informational material and "good practice guidelines" about day care.

All of the current efforts contribute toward the overall goal or achieving a better understanding of the needs of the children who are in Day Care as a basis for providing quality Day Care, taking into account a variety of factors including costs. The results of several of the projects initiated during FY 1975 and 1976 including, the day care cost-effective study and the parent survey, will provide data essential for activities having a direct impact on this goal.

The day care cost-effectiveness experience involves about 1,800 children and their parents and about 150 caregivers. The intended beneficiaries would be the consumers and providers of center-based day care. Accurate data is not available on the number of licensed day care centers currently operating, but the best estimate is that 720,000 children are served by those centers.

The Family Day Care Home Study involved 6 different grantees working with a total of 240 family day care homes, and about 1,440 children. Although accurate data is not available on how many children are served by existing family day care homes, the best estimate would be about 195,000 which should increase substantially by 1980.

Although much general information is available in the field of day care, a need exists for more specific usable information designed to aid the providers of day care at the Federal, State and local level in their efforts to deliver quality day care at reasonable cost levels.

In this regard, there is a need for more specific information about the benefits that children and parents derive from various day care programs and services as related to the cost of providing such programs and services. Information of this type is particularly important because policy makers at all levels of government as well as practitioners need this type of information to develop the best possible day care programs for the children at the lowest possible cost to the consumer. Little careful research has been performed on the relationship between major cost variables in day care, such as the ratio of center staff to children and the level of professionalism of a center staff, to benefits derived by children in a day care center.

Another need exists in the area of parent perceptions of what they consider to be important to their children in day care. Little reliable information exists to describe current usage patterns and different consumer preference patterns among various groups using day care, the actual and perceived barriers to the use of different kinds of day care, and the trade-offs parents would make between various levels of service and costs and between different types of arrangements and localities.

In addition, OCD has funded the first phase of a Day Care Supply study which will develop a supply model based on nationwide center level programs, staff and cost characteristics which can be used to simulate on a state-by-state basis, the impact of changes in FIDCR-type regulations on the availability and fee structure of public subsidies. It will also assess the impact of changes in local economic conditions on the supply of day care. Data will also be used to generalize the findings of the National Day Care Cost-Effects Study from the three target sites to the major day care market in the United States.

Head Start
(Dollars in thousands)

	FY 1975	FY 1976	FY 1977
Head Start Total	$441,000	$434,300	$434,300

Head Start is a comprehensive preschool program which serves children and their families, primarily those who are poor. It encompases a wide range of development activities including education, medical, dental, nutritional, social and other services with particular emphasis on parent involvement. Head Start funds full-year and summer programs. The full-year programs provide service either on a full-day or part-day basis. A variety of training and technical assistance activities are provided to local program staff to enhance the quality and effectiveness of the services offered. Head Start also conducts experimental programs such as the Child and Family Resource Program which provides family-oriented child development services according to the assessed needs of individual children, and Developmental Continuity, a program to facilitate continuity of educational and social gains made in preschool programs into elementary school.

For FY 1977 Head Start will assure that 10 percent of the enrollment opportunity in each State are available to handicapped children. This is in accordance with the legislative mandate contained in P.L. 93-644. Prior to FY 1976 Head Start had implemented a policy of making 10 percent of the enrollment opportunities nationwide available to handicapped children. Head Start now serves handicapped preschool children in an integrated setting with the non-handicapped and has established service delivery linkages with State and local agencies concerned with handicapped children.

The Head Start Policy Manual states that the appropriate duration of an educational or enrichment program for pre-school children is no more than six hours per day. Beyond this period, it is desirable for a child to "return to his own family unless there is no suitable caregiver in the home due to employment, illness or other reasons." Only in such cases may the basic Head Start program be supplemented to provide full day care for the child.

Low-income children and families, like other segments of the community, differ greatly in their need for child care and developmental services. Ideally, Head Start programs should be tailored to the special and diverse needs of each individual community and child, with particular emphasis placed on serving those with the greatest need. Thus, size permitting, each Head Start program should provide a balanced program of remedial and developmental services that reflects the full array of needs in the community.

Office of Education

Report on Day Care

(Fiscal Year 1977)

The Office of Education's role in providing day care services is limited to aspects of vocational home economics education and education for the handicapped programs. The day care role within these activities is focused on training workers for day care/child care occupations and providing services to handicapped children through the support of special demonstration projects. Moreover, such day care services are segments of broader program activities.

Vocational Education

The Vocational Education Act of 1963, Part F, Consumer and Homemaking Education, as amended, provides grants to States for educational programs which prepare youths and adults for homemaking and wage earner roles. An ancillary function of the Act and a general objective of vocational home economics education is the training of personnel to operate child care/day care development centers. Such training represents one component of comprehensive child care development programs. The day care courses are furnished in home economics in-school laboratories and centers which perform the dual role of training potential child care/day care workers and providing a conducive atmosphere for the growth and development of preschool children. Programs are developed on the local and State level with national technical support. Coursework may include training in child care and development occupations, infant, toddler and school age care, child nutrition, program planning, working with parents, foster family care, administration and supervision.

Since day care personnel training is part of comprehensive child care training programs which vary in scope according to locality, a breakdown of obligations specifically for day care courses is not feasible. Funding for child care development is made available under Consumer and Homemaking Educational grants which was supported at $35,994,000 in fiscal year 1975 and $40.994,000 in fiscal year 1976. Authorization for this activity terminates at the end of fiscal year 1976. Therefore, the fiscal year 1977 request for Consumer and Homemaking activities under Part F of the Act is included under the general authority of Part B, Basic Grants to States.

Enrollment in child care programs has increased from 8,453 students in fiscal year 1967 to 100,623 in fiscal year 1974. These figures represent enrollment in all child care development programs of which day care training is one component. Each fiscal year since 1972, approximately 375,000 preschoolers have received either direct or incidental day care services through vocational home economics child care programs.

Education for the Handicapped

The Handicapped Children's Early Education Program, Part C, supports demonstration preschool projects which are designed to stimulate the development of comprehensive educational services for handicapped children from birth through age 8 and their families. Several projects supported under this authority are located or cooperate with day care centers and programs. The cay care services provided are often incidental to the specialized education provided. The following projects furnished either direct or indirect day care services to handicapped children.

The National Capital Day Care Association, Inc. of Washington, D.C., has been funded to develop a three year demonstration project concerning specialized programming for preschool handicapped children. From fiscal year 1973 through fiscal year 1974, 55 children participated, 300 children were screened and 65 staff members trained. In fiscal year 1973, the project was funded at $59,897, in fiscal year 1974, 88,596, and in fiscal year 1975, $120,000. The fiscal year 1976 funding estimate is $60,000.

The National Urban League has been funded to demonstrate the possibility of developing a network of day care programs which would integrate handicapped children and non-handicapped children. From fiscal year 1972 through fiscal year 1974, 148 children participated, 300 children were screened and 75 staff members trained. In fiscal year 1974 the three sites in existence were San Francisco, California, Columbia, South Carolina, and St. Paul, Minnesota. In fiscal year 1972, the project was funded at $250,000, in fiscal year 1973 a time extension was granted with no additional funds provided. In fiscal year 1974 and fiscal year 1975, $150,000 was obligated each year.

The Saginaw, Michigan Child Development Center has been funded to develop a demonstration day care program to serve emotionally and mentally handicapped children so they may be assimilated into the public school system. In fiscal year 1975, 20 children have been served and $82,193 obligated for the project. For fiscal year 1976, 115,170 is being requested to expand the pilot program.

Potential School for Exceptional Children, Chicago, Illinois, a therapeutic day treatment center for traumatized infant-toddlers, preschoolers, and their parents in an urban area is designed to change young emotionally disturbed handicapped children's self image by alterning their daily life environment. From fiscal year 1974 through fiscal year 1975, 25 children participated, 35 children were screened and 60 teachers were trained. In fiscal year 1974, the project was funded at $65,000, in fiscal year 1975 $130,529 and the estimate for fiscal year 1976 is $130,000.

Alpha Plus Corporation DBA Circle Preschool, Piedmont, California has been funded to demonstrate the preparation of speech impaired and emotionally disturbed children (aged 3-5) for successful enrollment in regular and primary-grade classrooms by teaching them necessary survival skills in language and socialization from fiscal year 1973 through fiscal year 1975 51 children participated, 278 were screened and 140 teachers were trained.

The project was funded at $55,650 in fiscal year 1975, $82,155. For fiscal year 1976, $83,320 is being requested to begin their first year as an outreach project.

Mile High Child Care Association - Denver, Colorado has been funded to develop a demonstration model for training day care personnel to identify developmentally delayed and emotionally disturbed preschool children and to program for them within the regular day care setting. Since fiscal year 1974 120 children participated 400 children were screened and 51 teachers have been trained. In fiscal year 1974, the project was funded at $65,000, in fiscal year 1975 $102,924 and the estimate for fiscal year 1976 is $125,000.

Obligations for Projects Providing Direct and Indirect Day Care Services under The Handicapped Children's Education Program

Project	1974 Actual	1975 Estimate	1976 Estimate	1977 Estimate
National Capital Day Care..	88,596	120,000	60,000	60,000
National Urban League......	150,000	150,000	150,000	---
Saginaw, Michigan, Child Development Center.......	---	82,193	115,170	115,000
Potential School for Exceptional Children..........	65,000	130,529	130,000	130,000
Alph Plus Corporation DBA Circle Preschool.........	55,650	82,155	125,300	125,000
Mile High Child Care Association..............	65,000	102,924	125,000	125,000
Total.................	424,246	667,801	705,470	555,000

DRUG ABUSE

(Obligations)
(In Thousands)

	1973	1974	1975 Actual	1976 Estimate	1977 Estimate
Public Health Service:					
Alcohol, Drug Abuse, and Mental Health Administration National Institute on Drug Abuse..........	$181,283	$272,900	$219,813	$232,172	$247,827
Office of Education:					
Drug Abuse Education...	12,000	6,700	4,000	4,000	---
Elementary and Secondary Education, Title III.	1,600	1,600	1,200	728	---
Higher Education.......	106	100	55	---	---
Subtotal, Office of Education........	13,706	8,400	5,255	4,728	---
Social and Rehabilitation Service:					
Public Services Administration.......	37,852	41,600 1/	56,915	65,500	69,600
Office of Human Development:					
Rehabilitation Services Administration:					
Basic State Grants...	7,068	8,450	8,840	8,840	9,360
Expansion Grants.....	431	377	---	---	---
New Career Grants....	125	---	---	---	---
Rehabilitation Training	92	---	---	---	---
Research and Demonstrations.....	790	137	---	---	---
Innovation Grants....	---	---	---	---	---
Special Foreign Currency Program...........	---	18	50	50	100
Subtotal, RSA........	8,506	8,982	8,890	8,890	9,460
Total................	241,347	331,882	290,873	311,290	326,887

1/ This amount, the same as reported in the 1976 Hearings, is a preliminary actual. Actual dollars amounted to $45,072,000 (Source: OA-41.7(c) reports), and were used to project 1975-1977.

NATIONAL INSTITUTE ON DRUG ABUSE

Overview

Drug abuse in the United States, defined as "the illegal use of a controlled substance or use of a drug in a manner...that leads to adverse personal or social consequences," represents an economic and social cost to the nation estimated at $10.1 billion per year. Of this total, $6.3 billion is attributable to the value of property stolen to purchase illicit drugs. Lost productivity resulting from absenteeism, unemployment, and death represents $1.9 billion, while the cost of police activity, prosecution and maintaining prisoners is $620 million. Cost of medical care is $200 million. The remaining $1.1 billion annual cost represents all Federal and private prevention efforts in the United States devoted to drug abuse and drug traffic prevention.

Four major national surveys released by the National Institute on Drug Abuse (NIDA) in October, 1975, conclude that the use of illegal and legal drugs is continuing at a high level among many segments of the United States population. It is apparent that most young people are going to experiment with cigarettes, alcohol, and marihuana, but it is no longer accurate to see drug use as an inevititable movement from "experimentation" to "addiction." These surveys clearly show separate and distinct patterns of use: experimentation, occasional, regular, and heavy. It is clear that an individual can be in different stages with different drugs at different points in time. While there are a disturbing number of people who are frequent drug users, the majority of people who experiment with illicit drugs either discontinue use or use them occasionally, usually at low and moderate dosage levels. For example, of adult American males aged 20 to 30, six percent have experimented with heroin, three percent use it occasionally, and one percent use it on a regular basis. Another sample of high school seniors shows that 48 percent have experimented with marihuana, 40 percent used it occasionally, and six percent consider themselves daily users.

Three specific drugs of abuse -- heroin, marihuana, and cocaine -- highlight several critical drug abuse issues:

Heroin Heroin remains the nation's number one drug abuse concern. The health indicators strongly suggest that the heroin problem in America is not getting better. Although it is one of the most seldom used drugs within our general population, it accounted for more than half of the patients entering the Federally funded treatment system during the past year.

Marihuana Marihuana has joined alcohol and tobacco as one of the three most commonly used drugs in America. Today almost 20 percent of the adults and 23 percent of youth ages 12 to 17 have used marihuana, and seven percent of the adults and twelve percent of the youth are currently using it.

Cocaine A combination of factors has led to cocaine's resurgence as a more widespread drug of abuse. The emphasis on heroin, amphetamine, and barbiturate trafficking in the late 1960's may have encouraged some drug dealers to shift to cocaine because it was less troublesome to handle. The late 1960's witnessed a general upsurge of illicit drug use including cocaine. Cocaine has been touted by some as a "non-addictive, safe high." Many drug-related songs, movies, books, and articles reflected this social change, and cocaine was one of the drugs which was featured. Like all stimulants, including "speed" or methamphetamine, cocaine is non-addictive but has a very high abuse potential and is a clear health hazard.

In response to this serious national drug abuse problem, NIDA continues to strengthen its activities in the planning and implementation of a wide range of drug abuse prevention activities. Due to concern over recent indications of a national increase in heroin addiction, the Institute plans to increase its treatment capacity from 95,000 slots to 102,000 treatment slots. A maintenance budget will be adopted, enabling NIDA to support treatment projects at the prevailing declining match basis until the funding level for any given project is equal to 60 percent NIDA and 40 percent local share. NIDA will continue to support drug abuse treatment services at these rates until national health insurance, medicaid, or another viable third party source, which includes drug abuse treatment, can assume some portion of this expense. This long-term approach recognizes that the local sector is not in a position to accept further declination in the Federal contribution to the national treatment effort. This will allow the state role to be strengthened through greater reliance upon statewide contracts awarded through single state agencies as the primary treatment support mechanism. The states will be assisted in their efforts to develop procedures to capture third party payments for their programs, so that the Federal Government will be better able to phase down its treatment activities when, and if, these alternative funding sources come into being.

Other assistance activities supported by NIDA are assuming increased importance. A national data retrieval and dissemination system has been established and will be maintained to provide management, at both state and Federal levels, with essential programmatic, scientific, and technical information on the nature and extent of drug abuse in the United States. Resources available for drug abuse prevention efforts can be most effectively utilized when such questions as treatment service utilization, Federal and non-Federal funding activities, and changes in drug abuse patterns can be answered. This capability will greatly aid the states in assuming primary responsibility for planning and coordinating their drug abuse activities.

Since drug abuse prevention is a relatively new field, NIDA must provide assurance that treatment projects are operating in accordance with acceptable standards of performance. At the same time, a coordinated program is needed for career development of treatment workers. Toward this end, ongoing NIDA funded treatment service projects are monitored and audited by Institute staff to maintain treatment effectiveness. Specialized direct training or curricula packages are provided by the Institute-supported National Training Center to maintain a sufficient number of trained treatment workers to staff the national treatment network. NIDA plans to work with the single state agencies in establishing credentialing standards for all drug abuse workers, recommending minimum education and training requirements for each level and type of credential.

In assessing the effectiveness of NIDA-supported drug abuse treatment programs, it has been found that relatively poor results have been achieved with such groups as the young, minorities, women, and abusers of multiple drugs, particularly as measured by vocational rehabilitation and employment evaluation studies. Special demonstration programs, outside the scope of the traditional treatment setting, have responded to these findings by dealing with the special social, psychological, health, and other needs of these groups.

The final solution to many of our drug abuse problems continues to depend upon development of new knowledge on the causes, treatment, and control of such behavior. New treatment techniques, such as use of the therapeutic drug naltrexene, help block the effects of heroin. Investigations on behavior provide knowledge which has been directly translated into improved treatment procedures. Extensive data on the incidence and prevalence of drug abuse has begun to clarify usage patterns and trends in different age groups and in a variety of special populations. Additional marihuana studies are being undertaken in light of recent findings which raise questions concerning the possible effects of marihuana, particularly on the body's immune response system and cell metabolism. Progress is being made in determining those personality variables which may contribute to preventing or encouraging drug use in groups known to have above average risk of serious drug abuse involvement. NIDA's Addiction Research Center in Lexington, Kentucky, is concerned primarily with the nature of the addictive process and assessing the abuse potentiality of narcotic depressants, stimulants, and hallucinogens in an attempt to identify addicting drugs early and, through appropriate control, limit their abuse.

Summary Objectives for FY 1977

The Institute's drug abuse prevention efforts in FY 1977 will focus increasingly on developing the Federal role of providing assistance to the states in the management of treatment programs, and in their planning and implementing of adequate licensing and credentialing programs for facilities and workers in the field. Additionally, the Institute will be involved in projects designed to evaluate treatment effectiveness and in the development of new methods of treatment for special populations. These activities, together with continuing research directed at, among other things, development of alternative chemotherapeutical treatment approaches, evaluation for abuse potential of substances appearing on both the licit and illicit drug markets, and continuing evaluation of the effects of marihuana, reflect the major thrusts of the Institute's plan for FY 1977.

RESEARCH

Research programs of the National Institute on Drug Abuse (NIDA) are devoted to increasing our knowledge of narcotic addiction and drug abuse and to using this knowledge in formulating improved methods to deal with this problem in our society. Research projects sponsored by NIDA involve the participation of scientists representing all of the life science disciplines relevant to the problems of substance abuse. They range from fundamental studies on the mechanisms of drug action, which hold promise for ultimate understanding and eventual solution, to applied research and development activities.

The NIDA research effort is guided by six objectives or goals which provide a framework to describe its programs. Broad progress toward achieving these objectives, highlighted by several major achievements, characterize the accomplishments of the research programs during the past year. The initiatives planned for the next fiscal year build upon these accomplishments.

1. Epidemiology

The goal of epidemiological research is to determine the incidence, prevalence, and distribution of drug abuse and its effects on the individual and society. It involves exploration of the patterns, trends and extent of drug use at national, state, and local levels, as well as studies on samples drawn from varied cultural and ethnic backgrounds, and from differing age, sex, occupation, and other sociodemographic groups.

In FY 1976, NIDA launched a new nationwide survey of non-medical drug use in the general population; published findings from two surveys, one of Vietnam veterans and the other of young males now 20-30 years of age, which have caused revisions in the general conception of the nature of heroin addiction; initiated studies of drug use in industry and the relationship between drug use and working conditions; continued studies concerning drug use among students and other minority and high risk populations.

2. Etiology

The goal of etiological studies is to determine the causal factors, including those combinations of biological, psychological, and societal conditions, most associated with increased risk to drug abuse. It includes studies of the personality correlates and behavioral factors which may predispose individuals to abuse drugs; longitudinal research studies which are concerned with medical and psychological factors that may be predictive of subsequent drug use; and investigation of personality factors determining choice of drug abuse as an adaptive attempt or as a manifestation of psychopathology.

In FY 1976, work on the personality features of drug users have shown that 1) one of the earliest indicators of future drug use in adolescents is a preadolescent tendency toward rule-breaking and general rebelliousness; and 2) drug users exhibit certain psychological defense mechanisms in their attempts to adapt to their environment. Other projects are attempting to predict and explain narcotic addiction and abstinence in youthful populations and to develop equations which will predict this behavior.

Several new initiatives will be undertaken in FY 1977 to determine the psychosocial factors which play a role in the etiology of drug abuse.

Increased emphasis will be placed on two legal therapeutic drugs, barbiturates and amphetamines, in response to a re-evaluation of the size and seriousness of the abuse problem with these drugs.

3. Hazards

Another component of the NIDA research program includes studies which determine adverse effects of drugs on the physical and mental health of the individual and the consequences of drug abuse on society. These programs deal with the biological and psychological complications resulting from drug use including the effects on behavior and performance, such as driving. In FY 1976, new emphasis was placed on efforts to identify the relationships between drug dependence and such activities as criminal behavior, addictive lifestyles, and prostitution. These efforts toward elucidating the relationship between criminal behavior and drug abuse are being closely coordinated with the LEAA.

During FY 1977, our programs to evaluate pharmacological hazards will be expanded to include amphetamines and barbiturates as well as inhalents, in response to the evidence that abuse of these substances is increasing.

4. Treatment

The goal of treatment research is to determine the most effective therapeutic procedures for reducing drug abuse and its adverse consequences to the individual and to society. Included in this objective is the development and clinical evaluation of pharmacological treatment methods, including both antagonist and substitution approaches, synthesis and development of long-acting chemotherapeutic drugs, and investigation of innovative nonpharmacological treatment methods.

Chronic toxicity studies on drugs of potential use in treatment of narcotic addiction produced major findings in FY 1975. These pre-clinical animal tests accompanied ongoing clinical evaluations of the safety and efficacy of these drugs in humans. The drugs studied were naltrexone, a narcotic antagonist; levo-alpha-acetylemethadol (LAAM), a long acting narcotic that may replace or supplement methadone in therepy; and methadone, included for comparative purposes. These studies revealed that naltrexone was not toxic. Both LAAM and naltrexone are being developed as marketable drugs for the treatment of heroin addicts. In Phase II drug development (FY 1976), these drugs are administered to carefully supervised patients in research settings with emphasis placed on efficacy and on the early detection of possible toxicity. In Phase III (FY 1977), extensive clinical trials will be conducted under field situations with less monitoring and a larger sample of subjects (6,000) patients). One new initiative planned for FY 1977 is to combine pharmacological and behavioral treatment methods. Pharmacological approaches are necessary to help the addict deal with the sometimes overwhelming physiological changes resulting from the attempt to stop taking heroin; behavioral approaches are important to help him recognize and deal with situations in which he is most likely to crave drugs or revert to drug-taking. The application of learning principles to the study of drug abuse combined with pharmacological approaches may result in a major new treatment modality for drug dependent persons. During FY 1977 NIDA will initiate a long-term evaluation of patients receiving treatment in Institute-supported programs. When completed, NIDA will be in a position to articulate national post-treatment expectations and to establish a more accurate picture of the life history of the drug abuser.

During FY 1976, two substances were isolated, one in the brain and another in the pituitary, which may function as neurotransmitters or neuromodulators which modulate responses to pain or stress in a manner similar to opiate drugs. From the standpoint of understanding addiction, there is the possibility that synthesis or release of these substances is altered in addiction and play a basic role in the addiction process.

In the coming year we expect research to elucidate further the structures and mechanisms involved in drug abuse. An understanding of the cites of action of various drugs and their relation to specific behaviors may help in the development of chemical compounds which are specific for various aspects of the abuse problem such as drug-seeking, withdrawal, tolerance and dependence. New efforts will also be initiated to determine the commonalities between all problems of substance abuse. There is a growing body of thought which regards all substance abuse, whether it be of alcohol, tobacco, heroin or food, as fundamentally the same behavioral process. The apparent differences, namely the substance abused, may by only a superficial characteristic of the underlying problem. Concepts which unify substance abuse under one theoretical formulation suggest the possibility of common therapeutic strategies.

5. General Research Support

General research support is provided for the development of methodological and other types of resources required to further drug abuse research and as a means of ensuring maximum utilization of presently available information. Included in this category are the psychosocial/biological research centers which consolidate human and technical resources within collaborative organizational settings, maximizing both the development and the outcome of drug abuse research. Other activities supply controlled drugs and chemicals to the research community; develop and test sustained release delivery systems; and operate a management system which identifies research areas requiring greater emphasis while summarizing the nature and distribution of existing programs.

In addition to its grants and contracts program, the Institute supports the operation of the Addiction Research Center (ARC) in Lexington, Kentucky. Research activities at the Center are directed primarily at the nature of the addictive process and at assessing the abuse potential of narcotic depressants, stimulants, and hallucinogens in an attempt to identify addicting drugs early and, through appropriate control, limit their abuse. ARC operations include identification of narcotic antagonists that may have potential usefulness in the treatment of heroin addicts; validity of chemical methods for detecting drug use and dependence; and the behavioral and biological basis of addiction.

6. Research Career Development Award

These long-term awards to personnel with demonstrated drug abuse research potential enable the recipients to prepare for independent drug abuse research in a productive scientific environment. This budget will support the continuation costs of awards already committed, provide for 17 new projects, and thereby help ensure a competent future pool of drug abuse researchers.

Summary Objectives for FY 1977:

NIDA will continue its existing efforts to determine the physiological mechanisms and sites of drug dependency, and to develop more effective treatment methods. The following new programs will also be funded in FY 1977: an expanded Research Career Development Award program; a prospective study of the long-term effects of chronic marihuana use; an attempt to develop combined pharmacological and behavioral treatment methods; large-scale human trials of narcotic antagonists; and integrated substance abuse studies.

TRAINING

The drug abuse training program seeks to ensure the availability of qualified manpower in treatment programs. As a major share of this responsibility is transferred to the various states, through the combined efforts of the regional resource centers, the National Training Center, the state training support program, and technical assistance by NIDA personnel, the Institute will concentrate upon augmenting the national training effort through such activities as designing training models for states, and developing criteria for assessment of work experience in terms of academic credit required for credential recognition. A total of 3,775 persons will receive training in FY 1977. Principal mechanisms of support are as follows:

1. Grants: Training Grants are awarded under the authority of the Public Health Service Act (Section 303) to non-profit institutions for specialized training programs in the prevention and treatment of narcotic addiction and drug abuse. The training that medical students and students in health related areas receive on drug abuse is improved by increasing the knowledge of academic faculty and by developing regular courses of instruction. Other programs support training of persons who come into direct contact with drug abusers as well as specialized inservice or short term instruction on treatment, rehabilitation, prevention, and evaluation of training methods. Training topics include pharmacology, urine surveillance, medical problems and patient care, treatment modalities and their management, and individual and group techniques for working with the addict. In FY 1977 support will again be limited to continuation funding of a select number of training grant projects with no new programs being initiated.

2. Research Fellowships: Under the provisions of the National Research Service Award Act of 1974 (P.L. 93-348) individual and institutional awards are authorized to provide degree-oriented training support for aspiring bio-medical and behavioral research manpower. Support for this program will be increased from $197,000 in FY 1976 to $500,000 in FY 1977.

3. Contracts: Contract funds support the operation of the National Drug Abuse Training Center in Washington, D.C. and three regional resource centers. The center continues to serve as a model for developing, validating, and testing training materials, techniques, and methodologies which have application for training workers in community drug abuse treatment, rehabilitation, and prevention programs. The Center provides limited training to Federal, state and local government officials, and other health professionals engaged in community programs to combat drug abuse. International training efforts are also handled by the Center. The primary effort for the National Drug Abuse Training Center in FY 1977 will be to further support states in the development of their training capability by assisting with credentialing procedures, standard evaluation, training of trainers, and the implementation of their statewide training systems. Funds are not provided for continuation of the regional training centers since it is anticipated that state programs will be sufficiently developed to preclude the necessity of continued support for regional centers. Contract funding in FY 1977 will continue to support, at reduced levels, awards to single state agencies for development of state training programs. There will be a total of 52 contracts at a level of $2,400,000, including the National Drug Abuse Training Center.

Summary Objectives for FY 1977

The National Drug Abuse Training Center will continue to develop and consolidate its role as the center of the national training system in the field of drug abuse prevention and treatment. The funding of training grants will continue to be phased out and support for fellowships will be limited.

TREATMENT

Treatment activities center on the maintenance of service programs for drug abusers. In FY 1977 priority attention will be directed toward ensuring that state and local agencies increasingly become the focus of direct treatment activities. The three major long-range goals of the Institute will continue to be: (1) maintenance of a fully utilized Federally funded treatment capacity until the demand for treatment abates and/or the states can accept additional responsibility in this area; (2) support for national treatment standards for controlling the quality of treatment; and (3) provision of technical assistance to the states to help them assume increased treatment responsibilities.

NIDA, as the lead Federal agency concerned with drug abuse treatment, has requested sufficient funds in FY 1977 to be able to adopt a "maintenance" treatment budget in which a fully utilized 102,000 treatment slot ceiling will be maintained. This maintenance budget enables NIDA to support treatment projects at the prevailing declining match basis until the funding level for any given project is equal to 60 percent NIDA and 40 percent local share. Some shifting of funded treatment capacity among communities is planned so that resources which are not being adequately utilized in one area can be shifted to another area in which there is an unmet need. In order to ensure attainment of the above goals, the Institute will provide program development, monitoring, and technical assistance support. A new treatment demonstration effort will be launched in FY 1977, focusing on two drugs which are being increasingly abused - amphetamines and barbiturates.

Treatment programs fall into four major categories. The first, assisting communities to establish treatment programs for narcotic addicts and drug abusers through the awarding of grants, is funded under the provisions of the Community Mental Health Centers Act, and the Drug Abuse Office and Treatment Act of 1972 (DAOT Act). Programs in the second category utilize the contract mechanism available under the DAOT Act to establish statewide service contracts with single state agencies under which individual projects are subcontracted by the states. The third category is a civil commitment program conducted under Titles I and III of the Narcotic Addict Rehabilitation Act (NARA) and is totally funded and operated by the Federal Government. The fourth category represents the Institute's efforts in drug abuse prevention and education. These categories are described in detail below.

The Community Assistance Grant Program

Staffing Grants (Sec. 203e, CMHC Act)

Staffing grants provide funds to pay a portion of the salaries of drug abuse treatment professional and technical personnel in community treatment centers. Only 23 of these staffing grants are now in existence because the newer drug abuse service project grants are more desirable from the recipient's viewpoint. The Federal funding level of these programs in FY 1977 will be approximately $13,013,000, providing 9,543 treatment slots.

Drug Abuse Service Projects Grants (Sec. 410, DAOT Act)

Drug abuse service project grants are awarded on a matching fund basis for the total operational costs of projects for the treatment of narcotic addicts and other drug abusers. To obtain an award a program must offer one or more of the following services: detoxification, institutional, or community-based aftercare. Since the initial funding of 16 projects at the end of FY 1971, this program has expanded to its current total of 181 projects and a Federal funding level of $70,697,000, providing for 49,877 treatment slots. Ninety-six of these programs, originally funded under Section 256 of the Community Mental Health Centers Act, are eligible for eight years support. The remaining 85 projects were funded since April, 1973 under the Drug Abuse Office and Treatment Act for three years of Federal support, with possible renewal for a total of three additional years. As indicated by its rapid growth, this program has been the mainstay of the Institute's community assistance grant effort. In FY 1977 it is estimated that six of the three year projects will be consolidated into three additional statewide contracts leaving a total of 48,607 treatment slots supported through this mechanism.

Demonstration Treatment Grants (Sec. 410, DAOT Act)

The purpose of these grants is to support and evaluate promising new theories or approaches relating to substance abuse treatment and rehabilitation services. Such projects include the following: innovative models to improve the quality of treatment and rehabilitation services; evaluation methodologies designed to determine program effectiveness; models for financing the cost of treatment and rehabilitation; and, studies which define appropriate treatment and rehabilitation approaches for client groups with unique cultural, geographical, and/or psychological characteristics. In FY 1977, 33 projects will be funded at a level of $10,208,000, including seven new projects at $2,000,000. New funding will focus on the abuse of amphetamines and barbiturates.

Formula Grants (Sec. 409, DAOT Act)

These awards are made under the authority of Section 409 of the Drug Abuse Office and Treatment Act, and were first made available in FY 1973. Financial assistance is provided to the states for planning, establishing, conducting, and coordinating projects for the development of more effective drug abuse prevention functions in the state and for evaluating the conduct of such functions. Funds are allocated to states based on a formula which measures the relative population, financial, and program need of each state. Federal funding through the formula grant mechanism will be maintained at $35,000,000 in FY 1977. Estimates have shown that the states are utilizing their formula grant funds in approximately the following manner: a) 13 percent for treatment and rehabilitation programs; b) 45 percent for prevention and education programs; c) 19 percent for training efforts; d) 9 percent for research initiatives, e) 4 percent for program evaluation, and f) 10 percent for administration. In FY 1977 formula grants will continue to serve as the mechanism through which states will assume coordinating responsibility for their drug abuse programs.

The Community Assistance Contract Program

Statewide Service Contracts (Sec. 410, DAOT Act)

This program is a cost-reimbursement, cost sharing, contractual mechanism through which the Institute can fund a number of drug treatment projects under the "umbrella" of the single state drug authority. This program began in FY 1973 with contracts awarded to the states of New Jersey, New York, and Texas. Currently this mechanism is operational in twenty-four states with increased effort anticipated in FY 1977. Subcontracts are awarded by the state to support local treatment projects which have the same basic objectives and requirements as the drug abuse service grants. This program is the primary mechanism by which states assume greater direct treatment responsibility for their drug abuse activities. The continued growth of the program is evidenced by the Institute's efforts to consolidate as many treatment programs as possible under this support mechanism. FY 1977 funding for this program will increase from $39,915,000 in FY 1976 to $61,717,000 in FY 1977 with the number of states participating increasing from 24 to 27. The total treatment capacity of 36,366 slots in FY 1977 includes 7,000 new treatment slots to expand treatment services in states where an unmet need still exists.

Demonstration Contracts (Sec. 410, DAOT Act)

Contracts are awarded for directed research in important areas for which the grant mechanism is inappropriate. This activity also supports the Drug Abuse Early Warning Network (DAWN), which is a cooperative effort with the Drug Enforcement Administration to collect data on a national basis regarding the current trends and extent of drug abuse. DAWN will be funded at a level of $910,000 in FY 1977.

Technical Assistance Contracts (Sec. 410, DAOT Act)

These projects enable NIDA to monitor the efficiency of the management, fiscal, and programmatic activities of Federally funded treatment programs, ensuring compliance with Federal funding criteria and maintenance of a fully utilized treatment capacity. Two technical assistance projects will be refunded in FY 1977 at a total cost of $1,750,000.

The Narcotic Addict Rehabilitation Act

Approximately 21,200 patients have received treatment under this civil commitment program since its inception in 1966. In the past, the inpatient phase of the program was conducted at the Clinical Research Center in Lexington, Kentucky and the Center at Fort Worth, Texas. Now that the treatment portion of these facilities has been transferred to the Justice Department, all services are being performed contractually at community facilities. There are currently 13 community-based agencies providing evaluation and examination, inpatient care, and supervised aftercare under projects administered by the Institute. Efforts are currently being made to integrate NARA agencies with community-based projects, community mental health centers, independent drug abuse service projects, and with the statewide service contracts. New civil commitments are diminishing with program support reflecting this decrease in FY 1977. Funds for this program have dropped from over $7,000,000 in FY 1972 to $1,102,000 in FY 1977.

Prevention/Education Grants (Sec. 410, DAOT Act)

This program has the following primary goals: development of national policy governing drug abuse prevention/intervention efforts, including comprehensive guidelines to be used by single state agencies and community planning groups; identification, evaluation, and support of model approaches to drug abuse prevention which promise to be effective and adaptable to side application; nationwide dissemination of pertinent research findings, policies, guidelines, and evaluations within the field. During FY 1977, fifteen continuation projects will be supported at a level of $1,744,000.

Prevention Contracts (Sec. 410, DAOT Act)

This program supports the continuation of projects initiated by the Special Action Office for Drug Abuse Prevention and transferred to NIDA at the expiration of the Office's authority in FY 1975. These projects provide the means for evaluating new prevention techniques and for disseminating information to various state and local prevention efforts. Examples are the Pyramid Project, which utilizes the services of qualified consultants to provide on-site evaluation and technical assistance to state and local prevention efforts; and, the National Search, which is conducted to identify and spotlight current examples of successful prevention programs in communities and develop them into national models.

Five such projects will be funded at a level of $2,020,000 in FY 1977.

Summary Objectives for FY 1977

The National Institute on Drug Abuse will strengthen its activities in the planning and implementation of a wide range of drug abuse prevention activities. Due to concern over recent indications of a national increase in heroin addiction, NIDA is increasing its support to partially fund 102,000 treatment slots versus the previous level of 95,000. A maintenance budget will enable NIDA to support community-based treatment projects at the prevailing declining match basis until the funding level for any given project is equal to 60 percent NIDA and 40 percent local share. NIDA will continue to support drug abuse treatment services in this manner until alternative sources of funding can be developed to assume a greater portion of this expense. This recognizes that the local sector is not in a position to accept a further contribution to the national treatment effort at this time. The state role will be strengthened through greater reliance upon statewide contracts awarded by NIDA through single state agencies as the primary treatment support mechanism. The states will be assisted in their efforts to develop procedures to capture third party resources for their programs.

SCIENTIFIC AND PROGRAM INFORMATION

The Integrated Drug Abuse Management Information System (IDAMIS) serves as the organizational framework for a variety of related management information systems which are operated by NIDA through its Division of Scientific and Program Information (DSPI). In cooperation with 53 states and territories and with the assistance of appropriate support contractors and private consultants, IDAMIS supplies program managers at the Federal, state, and local levels with accurate, timely, and useful information for planning, resource allocation, monitoring and evaluation. A variety of reports, both routine and special, are generated and distributed to appropriate individuals. The IDAMIS is constantly undergoing evaluation and changes made as deemed appropriate to enhance the ability of the system to be responsive to new information needs.

Integrated Drug Abuse Management Information System

IDAMIS consists of three (3) major systems: the Client Oriented Data Acquisition Process (CODAP), the National Drug Abuse Treatment Utilization Survey (NDATUS), and the Financial Management Information System (FMIS). Each system is designed to serve a different management information need and each is significantly different in its scope and operation.

Client Oriented Data Acquisition Process

CODAP is a subsystem of IDAMIS concerned with the monthly collection of client data regarding drug abuse phenomena in Federal drug abuse treatment agencies. The need for uniform client-related data collected on a recurring basis in Federal agencies was established under Public Law 92-255.

CODAP collects data through an Admissions Report and a Discharge Report at two crucial points in the treatment cycle: admission and discharge. Data derived from these two reports provide the major output sources of the system. These two reports, together with the Client Flow Summary (a transmittal sheet) constitute the reporting system for most treatment units. A fourth report, the quarterly Client Progress Report, is the only required from the Bureau of Prisons (BOP) for reporting the individual progress of BOP clients.

CODAP is designed to supply both the Federal and state levels of management information on demographic and educational characteristics of clients, client drug problems, client treatment modalities, client length of time in treatment and geographic indicators of drug abuse manifestation.

The following CODAP objectives have been established for FY 1976 and 1977: 1) to increase the reporting rate; 2) to improve data quality; 3) to complete a validation study and data analysis by June 1976; 4) to provide up to 36 states with adequate technical assistance to assure that they have a reasonable and independent data processing capability to analyze CODAP data; and 5) to create a historical file by linking admission and discharge reports.

National Drug Abuse Treatment Utilization Survey

The survey subsystem of IDAMIS, the National Drug Abuse Treatment Utilization Survey (NDATUS), is concerned with the inventory of all drug abuse treatment units regardless of source of funding. This inventory is conducted twice a year. It is designed to document essential management data in order to plan rationally the allocation of Federal funds to support drug abuse treatment throughout the United States. NDATUS provides information such as number of actual treatment slots and census of clients in treatment, utilization rates for specified treatment modalities, funding source and waiting list information. NDATUS also provides a mechanism for describing various trends relevant to changes in the structure and composition of drug abuse delivery care in the United States. Data from NDATUS is aggregated on a national, regional, state and program level.

The following NDATUS objectives have been established for FY 1976 and 1977: 1) to assist both NIDA and state management in forecasting treatment resource requirements for existing and future drug abuse treatment services; 2) to provide management with necessary and timely information to determine in what locations treatment services are needed; 3) to analyze general treatment utilization trends; 4) to conduct comparative analyses for the nation, regions and states; 5) to provide each state with a computer produced listing of all reported drug abuse treatment service units which can be developed into a state directory; and 6) to provide the states with technical assistance to ensure that they have the capability to analyze and use NDATUS data to generate program level management reports.

Financial Management Information System

The Financial Management Information System (FMIS) was developed and funded in FY 1975 as a model for state use to obtain the financial information necessary to effectively manage the grant and contract funds used in support of drug abuse programs. The system can be adapted and tailored to the individual needs of each state, with the capability of becoming a more comprehensive system at the state's option. It is designed to supplement existing financial management systems. FMIS is modular in design in order that individual elements may be implemented according to state preference. The four modules include: 1) Grant/Contract Identification Module - designed to capture information on state-funded grants and contracts; 2) Expenditure Module - designed to record expenditures against state-funded grants and contracts; 3) Program Income Module - designed to capture information on all drug abuse programs in the state regardless of program type or source of funding; and 4) Functional Cost Module - designed to capture cost-per-client in providing different types of drug abuse treatment services.

The FMIS model is now available for state implementation, with initial installation and demonstration of FMIS capability in the State of Texas.

The IDAMIS system collects, indexes, and abstracts drug abuse information of a technical and scientific data nature for the purpose of public dissemination in the form of reports, fact sheets, pamphlets, bibliographies, and other publications to Congress, Federal agencies, state and local units of government, the public, and special interest groups. Information is disseminated through a national network of participating organizations, including single state agencies and major universities.

1. Resources and Materials File (RMF)

The RMF contains abstracts of documents and audiovisual materials. Scanning of biomedical, pharmacological, social, and behavioral science literature in addition to more popular and unorthodox publications such as the underground press is conducted on a regular basis, and results in the Drug Abuse Current Awareness System (DACAS). The file contains standard and historically significant works ranging from the LaGuardia Report on Marihuana of 1944 to the Indian Hemp Commission Report of 1893-4, but is essentially composed of the most current studies in the field. The coverage of this file is monitored by comparing its holdings to current materials so that gap areas can be identified and filled. All computer entries are assigned an indexing code which defines the major subject area within which the document logically falls. Abstracts can be retrieved by searching on the subject area designations, title, author, year of publication, medium, or by a more complex procedure utilizing Boolean logic in combining index terms.

2. Clearinghouse Program File (CPF)

The Clearinghouse Program File consists of identifying data on drug abuse programs across the country. The following elements are included: program name, street address, city, state, zip code, phone number, funding and program type. The file is searchable on the individual and various combinations of those elements. The information is updated on a continuing basis.

3. Data Reference Module (DRM)

The DRM is a data bank containing information on socio-economic variables obtained from the Bureau of the Census 1970 national census. The system also includes 1971 and 1972 current population and survey data. The system will be updated quarterly and contain for all major communities data elements relating to their demographic and socio-economic characteristics, employment data, and other geographical entities. Update software being developed by NIDA will provide quarterly data updates from the Bureau of the Census for inclusion in the module.

4. Drug Abuse Warning Network (DAWN)

A joint funding arrangement between NIDA and the Drug Enforcement Administration supports a forecasting activity to collect representative information concerning drug abuse incidents: 1) identify drugs currently being abused and/or associated with harm to the individual and society; 2) determine existing patterns of drug abuse; observe changing trends and detect new abuse entities and combinations; 3) provide data for assessment of the relative hazards to health and the relative abuse potential for various substances; 4) provide data needed for national control and scheduling of drugs of abuse.

The information sources for DAWN are: 1) inpatient units of non-federal, short-term general hospitals (as defined by the American Hospital Association); 2) emergency departments, located in non-federal, short term general hospitals; 3) county medical examiners or county coroners; and 4) crisis intervention centers not directly affiliated with colleges and universities.

Project DAWN reports are received from participating facilities in 29 indicator cities, 23 of which are designated as saturation cities (i.e., an attempt is made to enlist each qualifying hospital in the SMSA into the reporting system). In addition, information is collected from a representative sample of emergency rooms and medical examiners so as to enable national estimates of visits and/or drug mentions in such facilities.

Summary Objectives for FY 1977

The major effort will center upon assisting the states in assuming a more participatory and supportive position in the collection of vital information for the planning and management of the drug abuse problem. Through the continued development of these information systems at the state level, the Institute's objectives of increasing the responsibility of the states and local programs will be further strengthened. In addition, work will be completed on the initial integration and coordination among the various systems required to establish the national information system on drug abuse. This will help to ensure that drug abuse prevention resources are being effectively utilized and efficiently managed within the confines of state and Federal requirements and regulations, and eventually will result in standardizing information across state lines, permitting comparison of various jurisdictions and minimizing costs.

OFFICE OF EDUCATION

Drug Abuse Education

The Drug Abuse Education Act of 1970 (P.L. 91-527), enacted December 7, 1970, authorized drug abuse education demonstration projects in schools and communities and dissemination of information on drug abuse. The program was designed to alleviate the drug abuse crisis among youth by promoting awareness and understanding of the nature of the problem and developing and disseminating prevention and early intervention strategies aimed at attacking the causes of drug abuse rather than merely treating its symptoms.

P.L. 91-527 expired on June 30, 1973. The program operated at reduced level in fiscal year 1974 under a one-year extension of the Act. In September 1974, the Act was amended and extended through June 30, 1977 under P.L. 93-422. Initially, the program funded projects in 55 State and territorial education agencies to develop curricula and conduct in-service training programs for local education agencies and supported 57 local school, community, and college-based demonstration projects.

As experienced with these and other projects accumulated, it became evident that virtually all communities have or could have some sort of drug problems, which vary widely in nature and scope from community to community. It became clear that a key factor in successful projects was coordination of the efforts of all segments of a community - family, school, church, social, health and civic agencies and local government.

It was deemed that the pervasiveness of the problem suggested that a realistic Federal role would be to provide training for school and community leaders to help assess and define their problems, state their goals in attainable and measurable terms, assess recommended strategies, methods and materials as tools appropriate to the realization of their particular goals and involve their communities in cooperative efforts.

In fiscal year 1973, in addition to continuing support for State education agency and demonstration projects, and the National Action Committee, the technical assistance area of the program, the program supported seven regional training and developmental assistance centers which provided two weeks of training and follow-up site assistance for 800 teams of five to seven individuals, bringing the total to approximately 1,700 communities served. In fiscal year 1974, an additional 240 community teams were trained, a nationwide program for training of and developmental assistance to 336 local school district teams in prevention and early intervention was initiated. Two models for the college level pre-service training of educational personnel were instituted. In one model, a total of 180 teams (900 administrators, faculty and students) from colleges of education were given three days of training and were provided follow-up assistance on request. In the other model, six projects for development and validation of pre-service training models were initiated. The National Action Committee was continued.

In fiscal year 1975 under the school-based primary prevention and early intervention program 200 additional local school district teams were trained at 5 regional training centers. The 6 preservice demonstration projects were continued for a second year. The National Action Committee continued to provide technical assistance to USOE funded projects as well as State Education Agencies and Single State Agencies.

Elementary and Secondary Education Title III, Supplementary Educational Centers and Services

Originally, the Commissioner made grants directly to local education agencies under Title III, ESEA, (P.L. 89-10). Beginning in fiscal year 1971, 85 percent of Title III funds were administered by State educational agencies, with fifteen percent to be used at the Commissioner's discretion.

The Title III State Plans program reported that over 83,000 students were in drug education classes in fiscal year 1972. These students were in 14 single component type projects and 26 multiple component type projects that studied the drug abuse problem. In fiscal year 1973, over 625,000 students were in drug education classes. These students were in 16 single component type projects and 30 multiple component type projects. It is estimated that the number of students served in fiscal year 1974 was about the same as in fiscal year 1973. It is expected that approximately 562,000 students will be served in fiscal year 1975 and approximately 310,000 students will be served in fiscal year 1976.

Higher Education Title I, University Community Services

Title I of the Higher Education Act of 1965 (University Community Service) pioneered the use of Federal funds to direct higher education resources toward the solution of the drug abuse problem before the enactment of the Drug Abuse Education Act in 1970. Since that time, Title I activity in this area has declined.

In fiscal year 1974, seven (7) projects included 5,000 participants. In fiscal year 1975 three projects dealing with drug abuse were activated reaching about 2,500 participants.

A rescission of all budget authority for Title I HEA activities is proposed for fiscal year 1976. No funds are requested for this program in fiscal year 1977.

Public Services Administration

Drug Abuse

The Public Services Administration has responsibility for administering the Social Services program authorized under Titles I, IV-A, X, XIV, XVI, and XX of the Social Security Act, as amended. Except for Guam, Puerto Rico and the Virgin Islands, Title XX superseded all of the authorizing titles cited above as of October 1, 1975.

Under Title XX, grants are made to States for services to eligible individuals based on income or public assistance status. States may choose the services they will provide, as long as each service conforms to at least one of the five goals stated in the Act.

Within the broad spectrum of services provided to eligible individuals are those directed at preventing, solving or alleviating problems brought on by drug abuse. It is estimated that States will expend $69,600,000 in Federal funds through the Social Services program in F.Y. 1977 for services related to drug abuse.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

DRUG ABUSE

Unless drug abusers are provided those services which will allow them to prepare for, enter, and remain in gainful employment, the long-term success of drug abuse treatment programs will be questionable. State rehabilitation agencies are important resources for providing services such as vocational evaluation, work adjustment, vocational training, counseling, and placement assistance to eligible drug abusers. The experience gained in serving alcoholics and the mentally ill has been carried over to working with these clients.

State vocational rehabilitation agencies usually serve drug abusers in close cooperation with specialized drug abuse treatment programs. The rapid growth of these programs has resulted in increased demands for vocationally-oriented services for treated drug abusers. State agencies must balance these demands with the service demands of persons disabled by a wide range of conditions, especially the more severely handicapped. A recent White Paper on Drug Abuse: A Report to the President from the Domestic Council Drug Abuse Task Force affirmed the need for continued cooperative programming.

State rehabilitation agencies are expected to continue to increase the number of drug abusers rehabilitated, in response to local needs.

Research and Demonstration projects concerned with drug abuse have shown the effectiveness of a drug rehabilitation program conducted under the auspices of a State Department of Mental Health. The project has been incorporated into the ongoing programs of the State under total State funding. Another project, conducted within the organization and policies of a psychiatric hospital has shown great success in rehabilitating psychiatric drug abusers. This project, currently in its last year of Federal support, is scheduled to be continued under hospital auspices as an ongoing unit of the hospital.

Number of Drug Abuse Rehabilitants

Fiscal Years	Persons Rehabilitated	
	Total	Drug Abusers
1973	360,726	3,958
1974	361,138	4,700
1975	324,039	4,200
1976	334,200 1/	4,300
1977	353,000 1/	4,400

1/ Estimated

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON POPULATION AND FAMILY PLANNING ACTIVITIES

A REPORT TO THE
HOUSE COMMITTEE ON APPROPRIATIONS

PREPARED BY

THE OFFICE OF THE DEPUTY ASSISTANT SECRETARY
FOR POPULATION AFFAIRS
OFFICE OF ASSISTANT SECRETARY FOR HEALTH

FEBRUARY 1976

TABLE OF CONTENTS

Page

I. INTRODUCTION 5

II. OFFICE OF THE SECRETARY 12

III. PUBLIC HEALTH SERVICE 13

Office of the Assistant Secretary for Health 13

Office of Population Affairs 13

Office of International Health 14

National Institutes of Health 16

National Institute of Child Health and Human Development 17

Food and Drug Administration 33

Health Services Administration 37

Bureau of Community Health Services 37

Indian Health Service 45

Bureau of Medical Services 45

Center for Disease Control 46

Health Resources Administration 48

National Center for Health Statistics 48

IV. SOCIAL AND REHABILITATION SERVICE 50

Community Services Administration 50

Medical Services Administration 51

V. EDUCATION DIVISION 52

Office of Education 52

VI. DHEW POPULATION AND FAMILY PLANNING ACTIVITIES:

Obligations, FY 1973-1977 55

INTRODUCTION

This report describes the population research and family planning activities of the Department of Health, Education, and Welfare.

Population research and family planning activities in the Department of Health, Education, and Welfare include support of services--making family planning information and services available and accessible; training--meeting the professional and lay manpower needs in health, social services, and education; research--promoting and supporting research and research training in the biomedical and broad behavioral aspects of fertility, sterility, population dynamics, and program implementation; and public education--increasing opportunities for sex education, public understanding of human sexuality, and information about family planning and population growth.

Family planning services, as an integral part of adequate medical care, have been routinely and easily available to the majority of the population. In his message to the Congress, President Nixon emphasized that "...no American woman should be denied access to family planning assistance because of her economic condition." Under the Social Security Amendments of 1967 (PL 90-248), subsidized family planning services are available through a variety of sources to some of those who want but cannot afford them. The Social Security Amendments of 1972 (PL 92-603) required that family planning services be offered and provided promptly upon request to all recipients of Aid to Families with Dependent Children (AFDC). The Social Services Amendments of 1974 (PL 93-647) added a Title XX[1] to the Social Security Act (SSA). Under Title XX, family planning services continue to be mandated for those AFDC recipients desiring them. States may also elect to provide family planning services to individuals whose family monthly gross incomes are less than 115 percent (or, at State option, a lower percentage) of the median income of a family of four in the State, adjusted for size of family.

The Family Planning Services and Population Research Act of 1970 (PL 91-572) established Public Health Service (PHS) Act Title X, the major direct source of Federal support for family planning services programs. PHS Act Title X was extended through fiscal year 1977 by PL 94-63.

Legislative Highlights - FY 1968 Through FY 1975

1. On January 2, 1968, the Social Security Amendments of 1967 (PL 90-248), which included the Child Health Act of 1967, were enacted. This Act established categorical project grants for family planning services and required that not less than six percent of the monies appropriated for Maternal and Child Health under SSA Title V be available for family planning services. This same legislation required that under SSA Title IV-A, the AFDC program, family planning services were to be offered in all appropriate cases. Acceptance of such services was to be voluntary.

1/ SSA Title XX applies to the 50 States and the District of Columbia. Family planning social services for Guam, Puerto Rico, and the Virgin Islands are available under SSA Titles I, IV, X, XIV, and XVI.

2. On December 24, 1970, President Nixon signed into law the Family Planning Services and Population Research Act of 1970 (PL 91-572). This Act was passed to assist in making comprehensive voluntary family planning services available to all persons desiring such services.

3. On October 30, 1972, President Nixon signed the Social Security Amendments of 1972 (PL 92-603). This Act made it mandatory to inform all recipients of AFDC of the availability of family planning services and to provide or contract for services to all eligible persons voluntarily desiring them. The Act imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which fail to provide these services to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent and increases the Federal share for family planning services under Title XIX -- Medicaid -- to 90 percent from a variable formula with a range from 50 to 83 percent Federal matching.

4. On June 18, 1973, PL 93-45 extended the funding authorizations in PL 91-572 one additional year to June 30, 1974.

5. On January 4, 1975, President Ford signed the Social Services Amendments of 1974 (PL 93-647). This law created a new SSA Title XX which places major responsibility upon the States to develop their social services programs to be responsive to the needs of the citizens of each State. Title XX continues to require that family planning services be offered and provided promptly to those AFDC recipients desiring such services. States may also elect to provide family planning services on the basis of income eligibility status. In addition, States must provide three services to recipients of Supplementary Security Income (SSI) payments to the aged, blind, and disabled, of which family planning can be one service. The Federal share of matching continues at the 90 percent rate.

6. Enacted on July 29, 1975, PL 94-63 extends PHS Act Title X through fiscal year 1977.

The two tables that follow list some of the functions carried out by Department of Health, Education, and Welfare (DHEW) agencies.

Table 1 summarizes DHEW family planning programs for delivery of services by function, local delivery agency, and DHEW operating agency with funding and program responsibility.

Table 2 summarizes other DHEW population and family planning programs (research, training, education, and evaluation) by function and DHEW operating agency with funding and program responsibility.

Table 1

DHEW Programs for Delivery of Family Planning Services by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Medical Services, Information, Counselling, and Referral	Hospitals and Clinic Services	HSA[1] -- Indian Health Service -- Bureau of Medical Services -- Bureau of Community Health Services SRS[2] -- Medical Services Administration -- Community Services Administration
	Health Departments	HSA -- Bureau of Community Health Services SRS -- Medical Services Administration -- Community Services Administration
	Voluntary Health Agencies	HSA -- Bureau of Community Health Services SRS -- Medical Services Administration -- Community Services Administration
	Private Physicians	SRS -- Medical Services Administration -- Community Services Administration

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[1] Health Services Administration

[2] Social and Rehabilitation Service

Table 1 (Cont'd)

DHEW Programs for Delivery of Family Planning Services
by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Information, Counselling, and Referral Only	Income Maintenance Agencies	SRS -- Assistance Payments Administration
	Public Social Service Agencies	SRS -- Community Services Administration
	Voluntary Social Agencies	SRS -- Community Services Administration -- Assistance Payments Administration
	Employee Health Services	HSA -- Bureau of Medical Services

Table 2

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Training Programs for Population and Family Planning	
1. Short-term Pre-Service and In-Service Training of:	
(a) Physicians, nurses, other professional health personnel	HSA -- Bureau of Community Health Services CDC[1]
(b) Social workers and other public assistance personnel	SRS -- Community Services Administration -- Assistance Payments Administration
(c) Teachers	OE[2]
(d) Subprofessional workers	SRS -- Community Services Administration HSA -- Bureau of Community Health Services OE -- Adult and Vocational Education
2. Curriculum Development for Above Programs	SRS -- Community Services Administration OE
Research Training in Population and Family Planning	NIH[3] -- National Institute of Child Health and Human Development HSA -- Bureau of Community Health Services CDC

[1] Center for Disease Control
[2] Office of Education
[3] National Institutes of Health

Table 2 (Cont'd)

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Education Programs	
1. Sex and Family Life Education at Elementary and Secondary School and College Levels	OE
2. Professional Schools	
(a) Physicians, nurses, and other health professions	HSA -- Bureau of Community Health Services
(b) Social workers	SRS -- Community Services Administration
(c) Teachers	OE
3. Curriculum Development for Above Programs	SRS -- Community Services Administration OE
Research	
1. Reproductive Physiology and Contraceptive Development; evaluation of safety and possible adverse effects	NIH -- National Institute of Child Health and Human Development FDA[1]
2. Social Research	SRS -- Community Services Administration HSA -- Bureau of Community Health Services HRA[2] -- National Center for Health Statistics NIH -- National Institute of Child Health and Human Development

[1] Food and Drug Administration

[2] Health Resources Administration

Table 2 (Cont'd)

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
3. Administrative Research	
(a) Utilization studies	SRS -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration
(b) Demonstrations in innovative service delivery mechanisms	
(c) Evaluation methods	HSA -- Bureau of Community Health Services HRA -- National Center for Health Statistics
Evaluation	
1. Overall Evaluation and Coordination	OS[1] -- Office of the Assistant Secretary for Planning and Evaluation OASH[2] -- Office of Population Affairs
2. Medical Services Evaluation	HSA -- Bureau of Community Health Services
3. Social Services Evaluation	SRS -- Community Services Administration -- Medical Services Administration

[1] Office of the Secretary

[2] Office of the Assistant Secretary for Health

II

OFFICE OF THE SECRETARY

Office of the Assistant Secretary for Planning and Evaluation

The Assistant Secretary for Planning and Evaluation has primary responsibility for the preparation of the five-year budget plan and the Department's program memoranda. This office is also responsible for the overall evaluation of the Department's programs.

The Office of the Deputy Assistant Secretary for Health Planning and Evaluation works closely with the Office of Population Affairs in the development of appropriate planning documents, program memoranda, and evaluation studies.

Office of the Assistant Secretary for Human Development

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary of HEW to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became part of a new Office of Human Development at HEW which focuses on groups of Americans with special needs.

While the Office of Child Development does not directly operate any programs on family planning, Project Head Start and other OCD demonstration programs such as Home Start and Child and Family Resource Programs make social services available to parents. Social worker aides and health specialists in these programs are in contact with community agencies that conduct planned parenthood education and distribute information on family planning. Much of the material published and distributed by these agencies encourages parents to space their children and to talk to a physician or social worker about family planning.

III

PUBLIC HEALTH SERVICE

Office of the Assistant Secretary for Health

The Office of Population Affairs (OPA) serves as a focal point for coordination of Department population research and family planning services activities. The Deputy Assistant Secretary for Population Affairs heads the OPA and has full line authority and responsibility for directing population research and family planning services within the health agencies. PL 91-572, the "Family Planning Services and Population Research Act of 1970," establishes the OPA by statute and delineates the functions of the Office as follows:

> The Secretary shall utilize the Deputy Assistant Secretary for Population Affairs--
>
> (1) to administer all Federal laws for which the Secretary has administrative responsibility and which provide for or authorize the making of grants or contracts related to population research and family planning programs;
>
> (2) to administer and be responsible for all population and family planning research carried on directly by the Department of Health, Education, and Welfare or supported by the Department through grants to, or contracts with, entities and individuals;
>
> (3) to act as a clearinghouse for information pertaining to domestic and international population research and family planning programs for use by all interested persons and public and private entities;
>
> (4) to provide a liaison with the activities carried on by other agencies and instrumentalities of the Federal Government relating to population research and family planning;
>
> (5) to provide or support training for necessary manpower for domestic programs of population research and family planning programs of service and research; and
>
> (6) to coordinate and be responsible for the evaluation of the other Department of Health, Education, and Welfare programs related to population research and family planning and to make periodic recommendations to the Secretary.

In addition to its primary program direction activities, the OPA serves as a staff office for the Assistant Secretary for Health. This function involves advising the Secretary, through the Assistant Secretary, on policy and new legislation; participating in legislative and fiscal planning; and preparing reports on departmental and inter-departmental activities for the Secretary and the Congress. The OPA also prepares staff documents for the Secretary and for the White House.

Besides direct coordination of DHEW programs, the OPA works in close cooperation with, and provides leadership to, population research and family planning activities of other Federal agencies.

A continuing partnership between the Government and other concerned organizations is essential. The past work of private agencies in population-related fields has laid a foundation on which the official agencies continue to build. Therefore, the OPA maintains effective liaison with interested public and private organizations.

The OPA also maintains close communication with the population centers of major universities so that training can be geared to actual needs as they are revealed in ongoing DHEW programs.

In order to stimulate concerned professional and citizen groups to develop family planning resources, the OPA provides leadership at regional meetings, conferences or similar activities.

The Office of International Health (OIH), a staff office to the Assistant Secretary for Health, is the focal point within the Department for international health relations and for policy development and program coordination relating to international health.

One of the office's responsibilities is the overall administration of the Scientific Activities Overseas (Special Foreign Currency) Program. This program enables the health agencies to use U.S.-owned excess foreign currency to support selected health research and related activities in designated foreign countries. The countries designated as excess currency countries by the Treasury Department for fiscal year 1977 are Egypt, Burma, Guinea, India, Pakistan, Poland, and Tunisia.

There are about 250 active projects under this program at the present time. These include twelve in the field of population and family planning representing a total obligated cost of $2.7 million in foreign currencies. Included among these projects are studies of thromboembolism and oral contraceptives, biochemical tests of sperm in relation to fertility, reproduction after early steroid treatment, tryptamine receptors in the isolated rat uterus, and methods of demographic projection analysis.

Despite the potential for such research in the excess currency countries, no new population or family planning projects were funded during fiscal year 1975. A number of new projects have been proposed for development and possible funding during fiscal year 1977. These include development of methods for reversible sterilization of men and women and of implantable contraceptive drug delivery systems, establishment of serum baseline levels of reproductive hormones in fertile and infertile couples, as well as studies directed toward improving family planning services and providing insight into factors which motivate acceptance of family planning.

The office also provides services to the Agency for International Development (AID) on population and family planning programming and facilitates coordination and exchange among concerned U.S. and international agencies. The AID program provides assistance to about seventy developing countries through bilateral or regional projects. Many of these projects are implemented through AID contracts and grants to U.S. institutions and international agencies.

The OIH staff contributes mainly to those AID projects aimed at the development of more adequate systems for the delivery of clinical and educational services and the preparation of manpower. The services provided to AID include problem analysis, project design, identification of technical resources, review of project proposals, program evaluation, planning of training workshops, and guidance on implementation problems. This entails field visits to the AID assisted countries; working with international organizations; participating in AID task forces, committees, and meetings; and, provision of information and resource materials as requested by AID Missions, AID contractors, and individuals concerned.

Although not directed specifically at population and family planning programming, those areas comprise a significant element of the office's technical consultation services to AID in health planning and health sector assessment. The activities are conducted in a number of underdeveloped countries by OIH staff in cooperation with other consultants, AID Mission personnel, and foreign national officials of Ministries of Health and other health-related national agencies.

National Institutes of Health

The research programs of the Department in the population sciences are directed by the National Institute of Child Health and Human Development. Section 444 of the Public Health Service Act authorizes the Institute to conduct and support research and training relating to maternal health, child health, and human development, including research and research training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development. Section 1004 of Public Law 94-63 authorizes the Secretary of Health, Education, and Welfare to make grants and to enter into contracts "...to promote research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population..."

Total expenditures by the Institute in fiscal year 1975 for population research were $50.4 million. They are projected to be $53.8 million for fiscal year 1976. Of the projected expenditures in fiscal year 1976, $48.3 million is applicable under the authority of PL 94-63.

Other components of the National Institutes of Health provided $7.9 million in fiscal year 1975 to support a variety of extramural activities with important implications for population research. Research in reproductive endocrinology supported by the National Institute of Arthritis, Metabolism and Digestive Diseases totalled approximately $2.6 million in fiscal year 1975. These studies provide basic information essential in the development of new methods for controlling reproductive processes. The National Cancer Institute's interests in reproductive endocrinology, other reproductive processes, and carcinogenic effects of synthetic estrogens are relevant to understanding normal function and fertility control. In fiscal year 1975, $2.0 million was spent to support these studies.

The National Heart and Lung Institute awarded $0.3 million for studies of the effects of estrogens, progestogens, and steroid contraceptives on blood clotting mechanisms and the physiology of circulation. Several studies in reproductive neuroendocrinology and genetic aspects of reproduction were supported by the National Institute of Neurological and Communicative Disorders and Stroke and the National Institute of General Medical Sciences, respectively. Support for population research in these two Institutes totalled about $0.5 million in fiscal year 1975. The Division of Research Resources administers approximately $2.5 million in general research support relevant to the population field.

The National Institute of Child Health and Human Development (NICHD) and its Center for Population Research (CPR) have primary responsibility for the Federal effort in population research. This report describes research on the development of new means of fertility regulation, the evaluation of contraceptive methods currently in use, and the analysis of social and behavioral determinants and consequences of population size, composition, and distribution. It also discusses the NICHD effort in fundamental research in reproductive biology and the social sciences, upon which advances in contraceptive development and the solution to population problems are dependent. Finally, it describes the Institute's program to support institutions, develop scientific manpower, facilitate the coordination of Federal population research programs, and disseminate population research information.

A. Biomedical Research

1. Contraceptive Development

The contraceptive development program has continued to consolidate its priorities in the applied fields of drug synthesis and testing, exploration of new approaches to fertility regulation, development of new testing systems for drug evaluation, and the support of directed biomedical research in specified areas. The approach has emphasized both seeking entirely new drugs and exploring the contraceptive potential of existing drugs that are already approved for human use. The fact that contraceptive drugs are used on a chronic basis requires exhaustive safety studies in a variety of animal models, making the process of drug development both lengthy and costly.

The plan during fiscal year 1975 called for the concentration of human and fiscal resources on those projects having the greatest potential for improved contraceptive technology. A systematic review of ongoing projects has helped identify critical areas in the process of drug and device development, resulting in improved program performance. Limitations in both manpower and funding preclude the pursuit of a number of leads and necessitate hard management decisions to reach the goals stated in the five-year plan. The drug synthesis program, therefore, is restricted to the development of relatively simple chemicals and avoids the isolation and purification of substances from natural sources. The small size of the Center's primate colony dictates that only drugs which have undergone exhaustive testing in other species will be evaluated in primates. The Center's ability to pursue esoteric leads in the ovulation detection area is also limited. The following sections describe some of the important developments in those research areas selected for emphasis during fiscal year 1975.

a. Drug Development

Drug Synthesis Program. The drug synthesis program has identified several potentially useful compounds which have undergone preliminary screening in animals. The precise mode of action of these new chemicals is still unclear, but they have shown contraceptive activity in female laboratory animals. More extensive testing is awaiting synthesis of larger quantities of these chemicals. Their effectiveness cannot presently be ascribed to their known endocrine activities.

Several estrogens that were previously identified for continued exploration have undergone preliminary assessment in non-human primates. Available data suggest that their antifertility activity may be no greater than that of presently available drugs. These results point to the high risk inherent in the development of new contraceptive drugs. Work with these compounds during fiscal year 1976 will confirm or refute their superiority over existing products.

The inhibitors of luteinizing hormone releasing factor (LRF - the biological substance which causes ovulation) have been shown to block ovulation in rats and hamsters. New modifications have improved both the potency and duration of action of these compounds. Plans are in progress to evaluate their activity in non-human primates. The field of LRF inhibitors continues to be one of the more promising areas of the drug synthesis program.

Another promising lead involves a new compound which has been shown to block ovulation in hamsters. This simple compound was originally isolated from blastocysts (fertilized eggs). Its structure has been identified, and quantities of it have been synthesized. Several laboratories are conducting studies to determine its full sphere of activity. This advance is a good example of cooperation between scientists involved in basic and applied research.

Drug Synthesis Facility. Until recently a major bottleneck in evaluating new chemicals has been their initial lack of availability in sufficient quantities for research purposes. Invariably, the initial synthesis involves the production of only small quantities of these substances. The Institute's expanded synthesis facility will have the capacity to provide larger quantities of compounds that have been identified as potentially useful. Present plans call for rapid synthesis of several compounds, and a sufficient backlog of structures exists to keep this facility operating at peak efficiency. Its full potential should be clearly apparent during fiscal year 1976.

Biological Drug Testing Facilities. The biological testing facilities have continued to provide the contraceptive development program with rapid preliminary and in-depth evaluation of new drugs. Operational changes have resulted in more rapid assessment of drug activities. This increased efficiency should conserve funds by reducing the time required for decision-making.

Male Contraception. The new clinical trials of male contraceptives have not been implemented in fiscal year 1975 because regulatory requirements could not be completed as originally scheduled. All preliminary requirements have now been satisfied, and these trials will begin early in fiscal year 1976. They should assist in determining whether the administration of synthetic male hormones is a reasonable approach to male contraception.

New approaches to male contraception are presently being tested in monkeys. These animals may prove to be a good model for ascertaining biological activities in humans.

b. Device and Systems Development

Drug Delivery Systems. The study of new biodegradable drug delivery systems has reached the stage of comprehensive evaluation in different animal models. Advances in drug microencapsulation permit the use of syringes for administration instead of requiring subcutaneous implants, thereby improving their acceptability. Animal studies suggest that steady release of a drug can be accomplished, but considerable research is still required before human experimentation can be undertaken.

These drug delivery systems have the potential of improving not only contraceptive methodology but also therapeutic techniques in other areas of medicine. Fiscal years 1976 and 1977 should provide crucial evidence in this complex research area.

Long-Acting Injectable Contraceptive. During fiscal year 1975, the NICHD let a contract for the evaluation of one promising long-acting injectable contraceptive for women. The initial three-year contract calls for the studies in both animals and humans which are required by FDA regulations. This drug is presently being tested on a much wider scale in other countries, and the results obtained in those trials will guide the Institute in making future decisions.

Devices. The fluid-filled IUD has been tested in 300 women volunteers. Preliminary results were encouraging. However, as the number of IUD insertions increased, it became apparent that the expulsion rate for these devices was so high as to limit their utility. Surveillance of the women who did not expel the device is being continued during fiscal year 1976, but no new insertions will be made.

The instrument (steerable hysteroscope) used for viewing the uterine cavity and identifying openings of the Fallopian tubes has been used successfully in women undergoing procedures such as D & C (dilatation and curettage), hysterectomy, or laparoscopy for benign diseases. It therefore appears that the utility of this instrument has been successfully demonstrated. During fiscal year 1976, the steerable hysteroscope will be compared to commercially available rigid instruments in order to ascertain its advantages or disadvantages.

The development of devices for occluding the tubal openings and thus rendering the patient infertile has been slow. It is doubtful whether rigid or semi-rigid plugs can be safely inserted in human Fallopian tubes. The non-surgical occlusion of Fallopian tubes has been a universal problem, and new approaches are being implemented to solve it. During fiscal year 1976, the NICHD plans to ascertain the value of the new tubal occlusive systems.

c. Non-Contraceptive Fertility Regulation

Natural Family Planning. During fiscal year 1976, the NICHD plans to sponsor research to determine the efficacy of the Billings' method (cervical mucus technique) of natural family planning. This method of fertility regulation is dependent on teaching women to perceive their reproductive status as revealed by the nature and extent of cervical mucus secretion. Prior to ovulation and for several days thereafter, the mucus is copious, fluid and lubricating, and it is at this time that coitus should be avoided. Because the method is not dependent on drugs or devices, it has special appeal to certain segments of the population.

Ovulation Detection. Fertility regulation can be accomplished by the avoidance of coitus about the time of ovulation. However, there are no practical methods for pinpointing the time of ovulation of women. Availability of a reliable, simple, and inexpensive method for ovulation prediction would permit a woman to identify the safe and unsafe period of her cycle. The Institute has funded several projects to develop such methods. This program may be expanded in fiscal year 1976 to incorporate additional projects.

d. Directed Fundamental Research

There has been a reduction in contract support of fundamental research. Nevertheless, important advances have been achieved in several areas.

Cervical Physiology. The cervix serves as a barrier between the uterus and the vagina and can either facilitate or impede sperm transport. The fluid (mucus) secreted by the cervical glands serves as the primary controlling factor in sperm transport and survival. Research on the cervix of the human and the non-human primate indicates that this organ has steroid hormone receptors similar to those of the uterus and that these receptors probably control cervical function. Alteration of the circulating levels of estrogen and progesterone (hormones) changes the number of receptors and influences mucus composition. Research on cervical mucus during various stages of the menstrual cycle is helping to identify the biochemical components responsible for its viscous or fluid properties, characteristics which appear to have a direct bearing on fertility.

Pregnancy Determination. The availability of a test for reliably diagnosing pregnancy at the earliest possible stage is critical for the contraceptive development field since such a test provides a rapid assessment of the success or failure of a particular contraceptive method. Collaboration between NICHD scientists and researchers at other institutions has resulted in the development of a reliable and simple test kit. The Center furnishes these test kits to scientists all over the world.

2. Fundamental Biomedical Research

The goal of the fundamental biomedical research program is the acquisition of knowledge required to: (1) enable men and women to control their fertility; and (2) free individuals from reproductive disease and disability. A better understanding of basic reproductive processes is required for the development of safe, effective, and acceptable measures for the control of fertility and for the alleviation of infertility. Moreover, such additional knowledge of reproductive mechanisms is required for the prevention, alleviation, and cure of a host of reproductive diseases including breast cancer in women and prostate tumors in men.

To acquire the knowledge required for the control of reproduction and reproductive diseases, the Institute supported approximately 450 research projects in fiscal year 1975. These investigations on men, women and relevant animals encompassed a broad range of reproduction research areas including female fertility, male fertility, fertilization, gamete transport, reproductive endocrinology, reproductive behavior, and reproductive diseases. While many advances were made, the following are of special significance in their implications for new leads to fertility regulation, the alleviation of infertility, and the prevention and cure of reproductive diseases.

A major effort of the Center's basic research program is aimed at understanding how hormones control reproduction. Such understanding will afford an opportunity for the manipulation of hormone action in order to solve reproduction problems. Through their action on reproductive organs and feedback interactions with the brain, the sex steroid hormones regulate such reproductive events as ovulation, sperm development, egg transport, preparation of the uterus for the attachment and maintenance of the developing embryo, breast development and secretion, action of the prostate gland, labor, and birth. It now appears certain that sex steroid hormones function by activating genes in their target organs, for example, ovary, testis, uterus, etc. Investigators supported by the NICHD reported remarkable progress in elucidating the step-by-step manner in which genes are activated by estrogen and progesterone (the major sex steroid hormes in women). Interference with one or more of the steps in estrogen or progesterone induced gene activation could lead to the development of new measures for fertility regulation or for the alleviation of reproductive diseases.

There has been a resurgence of interest in the possible role of sex hormones in human cancer as a result of reports that the risk of vaginal and cervical cancer is substantially increased in the daughters of women treated with a synthetic sex hormone during pregnancy. NICHD-supported studies have revealed that an ovarian growth factor is secreted by the pituitary gland of the rat. Aside from its role in the promotion of normal ovarian cell growth, there is preliminary evidence that this factor may be involved in the development of ovarian tumors.

Perhaps the most important step in the mechanism of action of estrogen is the binding of the hormone to small proteins called receptors in target cells. The Institute is the major source of support for studies on sex hormone receptorology including: the nature and mechanism of action of hormone-receptor bindings; characterization and purification of receptors; receptor transformation; and translocation of hormone-receptor complexes to the cell nucleus, etc. In general, there is a gradual loss of estrogen receptors during development and progression of breast cancer. Such cancers are more susceptible to management by endocrine therapy when estrogen receptors are present. Thus, the detection of estrogen receptors aids the physician in selecting the 30% of breast cancer patients who may benefit from endocrine therapy. The NICHD is supporting similar studies of the mechanism of action of androgens (the male hormones) in male reproductive tissues, particularly the prostate. Knowledge of how androgens bind to receptors in prostate cells may be as important clinically in male reproductive physiology as knowledge concerning estrogen receptor action in breast cancer therapy is proving to be.

Of potential significance in contraceptive development is the discovery that the pineal gland of the rat, and possibly the cow, secretes a substance which can block luteinizing hormone (LH) secretion by the pituitary gland. LH is the hormone which acts directly to cause ovulation in women and indirectly to cause sperm formation in men. Thus, the anti-gonadotropin substance secreted by the pineal gland offers promise as a contraceptive agent in both men and women. Moreover, the demonstration in some animals that the anti-gonadotropin substance is a naturally occurring product of the pineal gland suggests that its use in fertility regulation might not be accompanied by significant undesirable side effects. Several NICHD-supported laboratories are making significant progress in the isolation, purification and characterization of the pineal anti-gonadotropin.

In the presence of normal blood levels of reproductive hormones, the fate of ovarian follicles is apparently determined to a large extent by the presence or absence of binding sites (receptors) for specific reproductive hormones. The cyclical appearance or disappearance of these highly specific receptors appears to be controlled by the reproductive hormones themselves. Since follicle growth, maturation and ovulation are caused by reproductive hormones, particularly the gonadotropins, it seems that the response of a follicle to these hormones is a function of the type and amount of receptors present. These new findings suggest that ovulation may be delayed or blocked by altering receptors within the ovarian follicle.

It has long been known that most follicles within the ovary do not release their eggs by ovulation. Instead, they develop to some extent and then die along with the eggs that they contain. This process by which follicles and eggs undergo partial development followed by death without ovulation is called atresia. Ovarian controlled mechanisms dictate that a few follicles ovulate, a great many more undergo atresia, and still more languish in the ovary without undergoing even partial development. An understanding of the mechanism which determines the fate of ovarian follicles should provide significant possibilities for both fertility regulation through inducing 100 percent follicular atresia and infertility alleviation through inhibiting atresia. Much new information regarding this mechanism has been reported recently by Institute-supported research scientists.

NICHD-supported laboratories have recently provided new information concerning the impact of environmental factors via the brain on reproductive events. In both males and females, stress-induced increases of the sex steroid hormones from the adrenal gland appear to have a definite role in modulating control of the gonadotropic hormones which regulate the ovary and testis. Such findings underscore the need to assess the interdependence of other endocrine glands as well as the brain with the ovary and testis in the control of reproductive processes.

3. Contraceptive Evaluation

The contraceptive evaluation program is concerned with evaluating current fertility regulating methods. The emphasis is on assessing hazards associated with their use and identifying risk factors which increase the likelihood of complications among those exposed to these methods.

A study involving long-term surveillance of a large number of women has identified several adverse responses to oral contraceptive exposure that are known to be related to cardiovascular disease. These include changes in blood glucose and lipid levels, blood pressure, body weight, and blood coagulability.

Two recently completed projects in the United Kingdom strongly suggest an increased risk of myocardial infarction among oral contraceptive users. The risk is particularly high in the presence of other factors known to be associated with cardiovascular disease such as obesity, hypertension, diabetes and smoking. Of considerable significance was the observation of a sizable increase in the risk of myocardial infarction among women on oral contraceptive steroids who were 40 years of age and over. It is urgent to develop definitive information on the quantitative risk and to fully explore other health characteristics of women which contribute substantially to the hazard of myocardial infarction associated with pill use. Such information should improve the safety of current contraceptive practice by advising women at special risk to use other methods of contraception. A major project to provide this essential data is projected for fiscal year 1976.

Several studies have identified an increased risk of hypertension among oral contraceptive users. However, no systematic investigations have explored risk factors of oral contraceptive induced hypertension, its natural history, reversibility and response to therapy. Furthermore, it is well know that certain ethnic groups have a substantially higher risk of hypertension. For these reasons, studies have been initiated to pursue these important areas of concern to oral contraceptive users.

A recently completed project on the relation of oral contraceptive steroids to thrombosis and thromboembolism has found that the relative risk of these complications is considerably reduced in women using oral contraceptive preparations containing less than 100 micrograms of estrogen per day, as opposed to preparations containing higher concentrations of estrogens. This is the only known serious complication of oral contraceptives where a change in formulation to low-dose estrogen pills has resulted in partial prevention of disease, namely, reduction in thromboembolism.

The clinical significance of the observed reductions in the levels of the vitamin folic acid among women on oral contraceptive steroids is being studied. The recent observation that cellular changes in the cervical epithelium of women on oral contraceptive agents disappear with supplementation of folic acid will also be explored.

Ongoing projects continue to explore the relation between various contraceptive methods and birth defects and other adverse manifestations among infants. Preliminary data from two of these projects have confirmed an increase in congenital malformations among the offspring of women who have been exposed to sex steroids early in pregnancy. The results from these projects should fill a major gap in current knowledge.

Studies are underway to evaluate the effects of oral contraceptives in different animal models. Projects involving various animal species will help in selecting appropriate animal models to study particular effects of contraceptive steroids. This should lead to improvement in predicting effects in man based upon observations in more suitable animal models.

Two recent studies of women with breast cancer who had been exposed to oral contraceptive steroids showed no increased risk of breast cancer as a consequence of oral contraceptive exposure. On the contrary, there was a decrease in benign breast lesions in women who used oral contraceptives. Surveillance of women exposed to contraceptive steroids for possible carcinogenic effects must continue despite the reassuring results of previous and current projects in this field. It is well documented from the study of known carcinogenic agents that there can be a long interval of 10, 20, or more years between exposure and appearance of cancer.

Vasectomy has become an increasingly common contraceptive method. The search for possible adverse manifestations of vasectomy includes evaluation of immunological effects as well as effects on the endocrine system and other body functions. Immune antibodies to sperm are rare before vasectomy but increase markedly within six to nine months after the operation. Implications for autoimmune disease are being explored. Two projects evaluating hormone levels after vasectomy have revealed no adverse effects thus far. Clinical studies also have revealed no evidence of disease attributable to vasectomy, although the number of men involved is small, and the follow-up period has been relatively short. Due to limitations in funding and staff, it was not possible to conduct the large cohort study of vasectomized individuals which was projected in fiscal year 1975. This project was to provide rapidly the information for overall assessment of the possible medical consequences of this procedure. A projected fiscal year 1975 study to purify available sperm antigen in order to improve the testing of certain immune responses to sperm was also postponed for lack of funds. These two projects are now scheduled to get under way during fiscal year 1976.

While serious complications associated with intrauterine devices are thought to be very rare, current information is inadequate to allow an assessment of the relative safety of one device as compared with the other. A collaborative project involving several investigators was initiated during fiscal year 1975 to provide the necessary case material for this complex and comprehensive investigation. Limitations in fiscal year 1976 funds may necessitate curtailing the scope of this IUD project since it may not be possible to fund all the selected collaborating clinical centers.

Investigations from other countries have strongly suggested that the risk of prematurity and low birth-weight is increased among pregnancies in women with prior induced abortions. This increase in prematurity may be due to the technique used in inducing abortion which, in some instances, may affect the function of the cervix. Because of the widespread use of induced abortion as a method of fertility control, three projects were developed to evaluate the risks on subsequent pregnancies. Limitations in funds necessitated postponing the initiation of these projects from fiscal year 1975 to fiscal year 1976.

B. Behavioral Sciences Research

Population research in the social sciences supported by the Center is concerned primarily with the factors governing population growth, distribution and characteristics and the impact of demographic changes on the health and welfare of individuals, families, and society as a whole. Such studies build the knowledge base required for developing rational population goals and for making informed decisions concerning policies and programs intended to attain these goals. Data collection relating to the measurement of population change and its components (fertility, mortality, migration) is largely the responsibility of the Bureau of the Census and the National Center for Health Statistics.

Of the variety of topics studied by the Center for Population Research, human fertility and the factors influencing it continue to receive the greatest attention because the birth rate is the major determinant of population growth and because fertility is so closely related to the well-being of families, mothers, and children. Since the consequences of population growth for society are so important in the determination of national population policies, that aspect also has been accorded considerable emphasis.

Special efforts have been made to develop research programs on topics of current importance, such as the effects of the changing roles of women on their childbearing patterns, factors affecting the choice of methods of fertility control, the effects of various childbearing patterns on parents and children, and the determinants and consequences of illegitimacy--particularly among teenagers. The latter topic has become more and more important as a major social issue in view of the rise in teenage illegitimacy that has occurred over the past decade, despite the increased availability of effective contraception and access to legal abortion. Since it has not been possible to pursue all of the important topics simultaneously, program emphases have varied from year to year to provide support for previously neglected areas or to build on research findings of recently completed studies.

In fiscal year 1975, for example, research emphasis related to the factors influencing effective contraceptive practice and to the consequences to parents and children of family size and childbearing patterns (age of mother, spacing of children, etc.).

1. Trends and Variations in Fertility

A book detailing the results of the 1970 National Fertility Study is soon to be published. In addition to indicating continued declines in expected fertility among American women, the study revealed increases during the 1960s in the use of the most effective contraceptive methods and in the proportion of the population approving abortion. It reported reductions in the rate of unwanted fertility and in historic income and religious differences in contraceptive practice, adding considerable insight into the reasons for the declining birth rate. A follow-up of the 1970 study is being undertaken to ascertain the stability and reliability of stated childbearing intentions and the factors influencing changes in stated intentions and in methods of fertility control.

The National Fertility Studies have been supplemented by several others dealing with (1) childspacing patterns; (2) the effect on fertility of separation, marital dissolution, and remarriage; (3) the prevalence of premarital childbearing; and (4) familial and work roles of women.

Other studies concentrate on population subgroups. One deals with the demography of the black population, emphasizing changes in fertility and other variables. Two studies investigate fertility among Spanish-Americans, which has traditionally been higher than that for the total United States population. A study of married couples of childbearing age explores cross-cultural differences in the motivation for fertility control, emphasizing the relationship between demographic, economic, social, and psychological variables and strength of motivation for contraception.

Several studies are attempting to explain the extraordinary rise in fertility that occurred after 1940, and its subsequent decline since about 1958. This rise and decline in birth rates in the United States are of special interest because both the rise and the subsequent declines were much greater than had been expected and because the impact of these tremendous swings in fertility on our national life has been so great. The currently prevailing theory which identifies economic change as a major factor in accounting for these trends has been seriously challenged and requires definitive testing. The studies initiated to subject this theory to more rigorous empirical tests deal primarily with the period of decline; therefore, future studies will concentrate on the period when fertility was rising.

Because the series of National Fertility Studies beginning in 1955 involved only women in the childbearing ages, the studies gathered no data on the cohort of women having the lowest completed fertility in American history--those born during 1901-1910. A recently initiated study is now analyzing the factors (age at marriage, family size aspirations, contraceptive methods, and possible economic influences) which enabled that cohort to achieve the lowest fertility recorded in the United States (an average of 2.3 births per woman). This study in historical demography is highly relevant to an understanding of current fertility trends. For a decade or more fertility has been rapidly declining, young people are delaying marriage, young married couples say they want relatively few children, and they are currently experiencing a period of relatively unfavorable economic conditions. Information about couples who went through similar changes at an earlier time is critical to determining whether the low fertility of the present is uniquely tied to a definite historical period or whether it is an expected response to certain kinds of social and economic change.

Studies of fertility changes in non-U.S. populations are establishing a more general understanding of the factors influencing human fertility. The most important of these has found that since the 19th century the poorly educated, rural population of Europe had reduced fertility by means of voluntary measures long before the changes which we associate with modernization occurred. The reduction apparently resulted from three conditions: (1) perception of the advantages to be gained from reduced fertility, (2) the acceptance of rationality in determining marital fertility, and (3) a knowledge of effective contraceptive techniques. This study has been influential in challenging the conventional wisdom that significant social and economic improvement is essential to reducing the high birth rates of developing countries.

2. Factors Affecting the Control of Fertility

A major thrust of the behavioral sciences program is to understand the factors that motivate couples to control their fertility and the processes by which they go about it. Some studies deal with the underlying social-psychological phenomena relating to fertility behavior. One study has found that those who appear alienated, powerless, or socially isolated are more likely to marry early and to have a higher incidence of premarital, early and unintended pregnancies.

Other projects have focused on female employment and fertility because of the long-observed negative relationship between the two phenomena. Research suggests that much of this relationship may be explained by underlying sex-role orientations, i.e., definitions of behavior appropriate for men and for women. The degree to which people recognize and adhere to these characterizations appears to influence fertility, the extent to which fertility is adapted to economic circumstances, and women's labor force activity. This area of research has been quite fruitful, and findings have converged from a number of exploratory studies. The most promising aspects of these projects will be incorporated into new research efforts during fiscal year 1976.

Since the setting of fertility goals and the use of contraceptive methods to attain those goals is usually done by the couple, rather than the individual alone, studies are focusing on the decision-making processes of couples regarding fertility-related behavior: how couples set goals, reconcile differences, obtain information about the consequences of having a child, and influence each other in evaluating and choosing methods of fertility control.

3. Illegitimacy and Pre-Marital Pregnancy

Data available from studies on illegitimacy and pre-marital pregnancy indicate that illegitimacy is a major social problem, and pre-marital conceptions, whether aborted or leading to forced marriage, create additional problems. The problems of illegitimacy and pre-marital pregnancy are greatest for teenagers, especially if they are black. One study has shown that 30 percent of women age 15-19 have had intercourse, with the black percentage about twice that of whites, and that sexual activity among unmarried teenagers is increasing. Moreover, teenagers are relatively poor contraceptors. About 30 percent of the sexually active teenagers become pregnant while unmarried, with the likelihood of pregnancy being four times as great for blacks as for whites. Two-thirds of the pre-marital pregnancies were unwanted and were followed by marriage in 44 percent of the cases, by illegitimate births in 42 percent, and by abortion in 14 percent. Ninety-five percent of all live births to black teenagers were conceived before marriage, and more than 90 percent of these births were illegitimate. Seventy-five percent of all live births to white teenagers were conceived prior to marriage, and 35 percent of these were illegitimate. Both maternal and infant mortality are higher for teenagers. In addition, teenagers constitute the largest group of late aborters, with the concomitant high risk. The implications of these facts for disruption of education, forced marriage with the high probability of subsequent divorce, the psychological and social consequences of illegitimacy, and the long term effects of early parenthood on the mother, father, child and society, indicate that further study to determine the factors associated with illegitimacy and pre-marital pregnancy is imperative.

Several studies, therefore, have been initiated on the social and psychological factors influencing the sexual behavior and contraceptive use of teenagers, and how the outcomes of pre-marital pregnancy are handled. A comprehensive review of the scientific literature is also underway to determine and evaluate research findings regarding sexual, contraceptive and reproductive behavior of adolescents in order to show promising directions for further research and draw together in an organized fashion what is already known in this area of study.

4. Consequences of Population Growth

The effects of population growth upon the individual and society have also been given attention. Several studies deal with economic consequences of population growth, with particular emphasis on per capita factors. These studies are concerned with the costs and disamenities of population growth which offset the economic benefits, and include evaluation of the impact of growth on the resource base and the environment. Preliminary results from one of the studies indicate that per capita GNP (gross national product) rises more rapidly when population grows more slowly.

5. Consequences of Family Size

Major emphasis in recent years has also been on the consequences of family size and childspacing for both parents and children. Couples and those who provide health services need more information on these effects. Studies have been initiated on the consequences of family size on child development and achievement, on the health of the child and the mother, on the marital stability and satisfaction of the parents, on the social and work roles of the parents, and on the economic welfare of the family.

A monograph prepared and published within the past year reports an inverse correlation between intelligence of offspring and family size, even when socio-economic status and intelligence of parents are taken into account. It explains this as an effect of reduced interaction with parents as family size increases, which adversely affects the verbal development and operative intelligence of children. A recently completed study similarly shows that educational achievement is lower the larger the family size, even when income is held constant.

Other studies are primarily concerned with health as a consequence of family size and childspacing. Research is also being conducted on the effects of family size on marital stability and happiness, and on social and work activities of marriage partners, particularly wives.

6. Distribution of Population

Several projects have dealt with population distribution in the United States. One developed into a Center for Population Research monograph on *Rural-Urban Migration Research in the United States: Annotated Bibliography and Synthesis*. Migration of individuals has also been studied to assess the influence of various socio-economic and familial statuses on the probability of making different types of geographic moves during a person's lifetime.

Another project has explored, through 1960 and 1970 Census data and through Current Population Survey data for 1961-1970, how individual and family income interact with other variables to influence decisions to move, the distance moved, and region of destination. It indicates such consequences of migration as effects on earnings, trends in income and fertility, and progress of children in school. Except for the slightly negative effect of migration upon progress in school, the burden of the findings is that migration is economically profitable both to migrants and the areas of destination.

For a number of years, migration was from the rural countryside and smaller cities to metropolitan areas, followed by a sizable movement to suburbia and a concentration of blacks within central cities. According to one study, blacks continue to be concentrated in central cities and in a few suburbs. However, the increasing receptivity of whites and the rising economic potential of blacks portend shifts of blacks to the suburbs with increasing residential and educational integration. A second study on non-metropolitan population changes found that the open Pennsylvania countryside is attracting more migrants than are the small non-metropolitan towns and cities, and that migrants appear to prefer non-metropolitan residence, but at sites within comfortable reach of the economic, social and cultural resources of larger cities. These findings are consistent with other research which is showing a turn around from migration into metropolitan areas to migration to non-metropolitan counties.

C. Institutional Development

1. Multidisciplinary Programs in Population Research

Leading institutions and research organizations receive assistance from the Center in the establishment and management of Population Research Centers and Program Projects in Population Research. Center grants support the core facilities and services required to enhance the quality and productivity of ongoing, multidisciplinary, population research programs of high quality. Program Project grants support multidisciplinary research programs consisting of at least three interrelated projects which have a common theme or focus on population problems.

During fiscal year 1974, ten Population Research Centers received support. During fiscal year 1975, twelve Centers were supported for the studies indicated: (1) Vanderbilt University - reproductive hormone actions and their molecular controls; (2) The University of Texas at Austin - population dynamics of minority groups; (3) Population Council at the Rockefeller University - fertility regulation and antecedents and consequences of fertility; (4) University of Wisconsin - demography and human ecology; (5) University of Chicago - molecular biology and human reproduction; (6) Johns Hopkins University - fertility in teenage women, male reproductive biology, and demography; (7) Baylor Medical College - molecular biology of reproductive processes; (8) University of North Carolina - behavioral-social population problems; (9) Columbia University - steroid biochemistry and female reproduction; (10) Princeton University - demography, population economics and statistics; (11) University of Pittsburgh - research in primate reproduction; and (12) Harvard University - reproductive biology and human reproduction.

During fiscal year 1974, eleven Program Projects received support. During fiscal year 1975, fifteen Program Projects were supported for the studies indicated: (1) Columbia University - reproductive endocrinology relevant to problems of human reproduction; (2) The University of Michigan - reproductive endocrinology from molecular to physiological levels; (3) The Northwestern University Medical School - molecular, cellular and tissue mechanisms operative in the action of hormones upon target cells and tissues; (4) The Oregon Regional Primate Research Center - factors which control the events culminating in fertilization in non-human primates; (5) The University of Pennsylvania School of Medicine - biochemical, biological, and morphological events in the early processes of reproduction and development prior to implantation; (6) The University of Texas at Austin - control mechanisms at molecular to organismic levels; (7) Harvard University Medical

School - reproductive biology, fertilization, embryogenesis; (8) Case Western Reserve University - reproductive biology of events from ovulation to implantation; (9) University of Texas at Houston - male reproduction function; (10) University of California at San Diego - gametogenesis and reproductive biology; (11) Washington University - hormonal regulation of the reproductive tract; (12) University of Washington - gamete transport in mammals; (13) Mayo Foundation - mechanism of action and molecular biology of estrogen, progesterone and the gonadotropins; (14) Salk Institute for Biological Studies - neuroendocrinology of reproduction and growth; and (15) Massachusetts Institute of Technology - migration and migration policies in relation to socioeconomic development.

2. Manpower Development

Training Grants. The Institute awards grants to institutions for population sciences research training programs and for the support of both predoctoral and postdoctoral trainees selected for study in those programs. During fiscal year 1975, NICHD awarded 27 population research training grants totalling $2,571,000 to 24 institutions in the United States. Of these 27 training grants, seventeen were awarded for research training in the biomedical sciences related to reproduction and 10 for training in the behavioral disciplines of the population sciences. Of the 147 trainees supported under these grants, 118 or 80 percent were predoctoral students and 29 or 20 percent were postdoctoral fellows.

The institutions which received population research training grants during fiscal year 1975 are: (1) University of Maryland; (2) University of Massachusetts; (3) University of Kansas; (4) University of Washington; (5) University of Texas, Austin; (6) Columbia University; (7) Medical College of Georgia; (8) Marine Biological Laboratory - Woods Hole; (9) University of Illinois; (10) Baylor College of Medicine; (11) Case Western Reserve University; (12) DePaul University; (13) Jackson Laboratory; (14) Washington University; (15) University of Wisconsin; (16) University of Chicago; (17) Princeton University; (18) University of California, Berkeley; (19) Brown University; (20) University of Pennsylvania (3 awards); (21) Johns Hopkins University; (22) University of Michigan; (23) Cornell University; and (24) University of North Carolina (2 awards). At the close of fiscal year 1975, three new awards were made to: University of Wisconsin, Vanderbilt University, and the University of Michigan.

Individual Postdoctoral Fellowships. In addition to institutional grants for research training, NICHD awards postdoctoral fellowships to individuals for training in population research. During fiscal year 1975, a total of $665,000 was awarded to 48 postdoctoral fellows. Of these postdoctoral fellows, 43 or 90 percent received training in the biomedical sciences related to reproduction and 5 or 10 percent received training in the behavioral disciplines of the population sciences.

Research Career Development Awards (RCDA's). The Institute awards RCDA's to outstanding senior postdoctoral candidates to enable them to devote full-time to the development of expertise in population research. These awards provide up to $25,000 to the recipients for a maximum of five years of support. Approximately $639,000 was spend in fiscal year 1975 for the support of 27 RCDA's. In addition, the CPR continues to support two Research Career Award recipients who received long-term commitments of support before the program was phased out.

D. Coordination and Communication

The coordination of Federal population research programs and the communication of population research information is accomplished through the following activities.

Interagency Committee on Population Research

The Interagency Committee on Population Research (ICPR) coordinates the population research activities supported by Federal agencies and fosters the exchange of information among Federal population research programs. The Committee was established by the Secretary of HEW on October 5, 1970, and has been extended through June 30, 1976. The ICPR is chaired by the Director of NICHD's Center for Population Research and reports to the HEW Deputy Assistant Secretary for Population Affairs.

Inventory of Federal Population Research

An important product of the ICPR is the Inventory of Federal Population Research which has been updated annually since fiscal year 1969. It represents a cooperative effort on the part of the Federal agencies that fund population research projects. The Fiscal Year 1974 Inventory reports that Federal agencies supported about $62 million in population research during fiscal year 1974, approximately $8 million or 15 percent more than the $54 million obligated in fiscal year 1973. This $8 million increase includes $6.2 million authorized under the fiscal year 1973 continuing resolution but not released for obligation until fiscal year 1974. The 837 population research projects funded during fiscal year 1974 represent an increase of 107 projects over the 730 reported in fiscal year 1973. HEW continued as the major Federal funding agency for population research, accounting for 89 percent of the $61.7 million in total funds obligated. The $55.0 million in HEW funds constituted a $10.9 million increase over fiscal year 1973, of which $6.2 million resulted from the release in fiscal year 1974 of fiscal year 1973 funds.

Analysis of Federal Population Research

The ICPR also prepared its Analysis of Federal Population Research--Fiscal Year 1974. This annual report summarizes and evaluates current Federally supported population research and recommends research to meet information gaps in the population sciences.

Inventory of Private Agency Population Research

The initial edition of the Inventory of Private Agency Population Research, which will be updated annually, was issued by the ICPR for 1973. This companion publication to the Federal Inventory includes projects sponsored by the principal agencies involved with research in the population sciences: the Ford Foundation, the Rockefeller Foundation, and the Population Council. In 1973 these three private agencies funded a total of $12.7 million in population research, representing a total of 392 projects. The Ford Foundation led with $7.6 million, or three-fifths of the three-agency total. The Population Council, with $3 million in grant expenditures, accounted for less than one-fourth of the total private agency funds, but sponsored more projects than the other two agencies combined, 227 out of the total of 392. The Rockefeller Foundation's program was the smallest of the three, $2.1 million for 44 grants.

Population Sciences: Index of Biomedical Research

The communication of information concerning biomedical research in the population field is enhanced through the monthly publication of Population Sciences: Index of Biomedical Research. This bibliographic citation journal is produced with the assistance of the National Library of Medicine and is based on information contained in the Library's Medical Literature Analysis and Retrieval System (MEDLARS). It is the counterpart of Population Index, a bibliographic journal devoted to population research in the social sciences, which the Office of Population Research at Princeton University publishes and which NICHD has helped support for several years.

Population Research Monographs

NICHD has initiated another important means of communication through its monographs in population research. The monographs review and evaluate the state-of-the-art in substantive areas of population research. They are published as individual books on a non-population research. They are published as individual books on a non-periodic basis by the Government Printing Office. The books usually contain an evaluative review of a field, annotated citations, and an analysis of the research required to obtain needed knowledge.

Publications of Workshops and Conferences

A number of publications have resulted from NICHD conferences and workshops in the population sciences. Articles and books published during fiscal year 1975 include the following:

Title and Year of Publication	Authors/Editors Publisher
Reproductive Behavior 1974	William Montagna William Sadler Plenum Press, New York
A Review of the Actual and Expected Consequences of Family Size 1975	Kenneth W. Terhune Government Printing Office DHEW Pub. No. (NIH) 75-779
The Effects of Oral Contraceptive Hormones on Nutrient Metabolism Part I - April 1975 Part II - May 1975	Articles by workshop participants The American Journal of Clinical Nutrition Bethesda, Maryland
The Demographic Evaluation of Domestic Family Planning Programs 1975	J. Richard Udry Earl E. Huyck Ballinger Publishing Co. Cambridge, Massachusetts

Food and Drug Administration

Programs of the Food and Drug Administration (FDA) of DHEW are authorized by the Food, Drug and Cosmetic Act of 1938, as amended. The FDA approves contraceptive drugs for safety and effectiveness before they are marketed and maintains surveillance over both contraceptive drugs and "non-drug" contraceptive devices (those which do not incorporate releasable metals or drugs) after they are marketed. FDA involvement in population research and family planning services lies primarily in:

(1) Sponsoring or monitoring the progress of research necessary to carry out its regulatory responsibilities relating to oral contraceptive safety.

(2) Using its regulatory functions with regard to the safety and effectiveness of contraceptive drugs and devices.

(3) Maintaining a reporting system which serves as a clearinghouse for information concerning adverse reactions associated with contraceptives.

The first oral contraceptive agents were approved by the FDA for general use in 1960. By 1975, there were over 50 such agents on the market. Several new drug applications are currently under review, including a three-month injectable contraceptive and a postcoital contraceptive.

Having published its "Second Report on the Oral Contraceptives" in August 1969, the FDA Advisory Committee on Obstetrics and Gynecology continues to assist in activities related to family planning. This Committee has participated in revising oral contraceptive labeling, in updating guidelines for clinical investigations of oral contraceptives, and in evaluating the influence of estrogen content in the thromboembolic action of oral contraceptives. The Committee has also deliberated upon the problem of the tumorigenic action of certain steroidal contraceptives and has assessed the safety and efficacy of certain systemically administered contraceptives and of intrauterine devices (IUDs) incorporating releasable metal or a hormone.

FDA provides expert advice to the pharmaceutical industry and the academic community in the conduct of studies to obtain data concerning the safety and efficacy of contraceptive drugs. In addition, FDA solicits the views of consumers and other interested parties on proposed consumer information materials to accompany the contraceptive market package.

In order to develop adequate information to assure the safety and effectiveness of contraceptive drugs and devices, the FDA has initiated several research projects. The FDA is supporting an investigation of the carcinogenic and diabetogenic potential of certain oral contraceptive steroids in long-range studies in Rhesus monkeys and beagle dogs at the International Research and Development Corporation in Mattawan, Michigan. These studies follow the protocol prescribed by FDA to the pharmaceutical manufacturers in 1967, and under which already marketed as well as investigational compounds are currently being evaluated. Since initiation of the studies, three investigational products have been found to induce mammary tumors in beagle dogs. Two marketed formulations containing tumorigenic progestins have been withdrawn by the manufacturers. The dog studies have been completed, and the Armed Forces Institute of Pathology has become the repository for all records, tissues, blocks and slides pertaining to the dog and monkey studies. The monkey studies are continuing. The long-range design of the investigations is intended to provide some indication of the possible carcinogenic hazard to long-term human users of the contraceptives.

The FDA is also gathering information regarding the possible association, in humans, between liver tumors and oral contraceptive use.

Utilizing funds from the PL-480 program in Yugoslavia, the FDA has developed four studies relating to oral contraceptive safety. A two-year study of 200 women at the Institute for Mother and Child Welfare in Zagreb, Yugoslavia, was conducted to assess the effect of selected oral contraceptives on carbohydrate and lipid metabolism. The final report from this research is expected before the end of 1975.

A second FDA study under PL-480 support has been initiated at the University Teaching Hospital for Obstetrics and Gynecology in Ljubljana, Yugoslavia. This study has two objectives: (1) To determine in a small study (offspring of 200 women) whether congenital abnormalities or abnormal karyotypes develop in the offspring of women using oral contraceptives within three months of conception. (2) To determine in a large study (over 28,000 women have been entered) whether oral contraceptives increase the risk of cervical cancer. A final report on the outcome of pregnancy study will be available during 1976. The cervical cancer study is ongoing, with data collection annually. The final study report should be available before the end of 1976.

A third FDA PL-480 project at the Institute of Hygiene and Social Medicine in Sarajevo, Yugoslavia, is expected to continue until 1979. This study also has two objectives: (1) To compare the changes in cervical cytology in 6,000 oral contraceptive users with those in a similar group of women using other family planning methods. (2) To study all women (7,600) delivering in three population centers to ascertain the possible relationship between abnormal pregnancies and malformed infants and the use of drugs, hormones, and exposure to environmental hazards.

A fourth FDA PL-480 study in Belgrade, Yugoslavia, originally scheduled for completion in December 1974, has been extended until June 1976. This four-year study is aimed at investigating the effect of oral contraceptive use on coagulation mechanisms.

Recognizing that prostaglandins may have significant potential in family planning, the FDA is monitoring ongoing prostaglandin research and has developed protocols for pharmacological and clinical investigation of these products. During 1973, the FDA approved the use of prostaglandin as a second trimester abortifacient. In addition, studies are being conducted to evaluate the use of prostaglandins in inducing labor at term, in missed abortion and intrauterine fetal death.

Proposed revisions to the oral contraceptive labeling directed to physicians were presented by the FDA to its Obstetrics and Gynecology Advisory Committee on July 17, 1975, for evaluation. When finalized, the revised labeling will be put into use.

In the June 5, 1971, Federal Register, the FDA Commissioner published a proposal to make intrauterine devices which incorporate heavy metals, drugs, or other added substances, "new" drugs. Thus, a "Notice of Claimed Investigational Exemption for a New Drug" must be submitted to the FDA to cover clinical investigations of the safety and efficacy of such contraceptives. In addition, an approved New Drug Application is required for marketing such devices.

Although the FDA does not currently have pre-marketing control over non-drug intrauterine devices, it maintains surveillance over such devices after they are marketed to insure their safety and efficacy. In June 1974, when the safety of the Dalkon Shield IUD was brought into question, the FDA set up an ad hoc Obstetrics and Gynecology Advisory Committee to evaluate the available data and make recommendations to the FDA Commissioner on the safety and efficacy of IUDs in general and the Dalkon Shield in particular. Following the August 1974 public hearing on the Dalkon Shield and other IUDs, the Committee determined that "IUDs have been shown by extensive use and studies to be a safe and reliable means of contraception and they compare favorably with the standard in this field--namely, oral contraceptives." The Committee also assigned a special subcommittee to review data pertinent to the Dalkon Shield. Having reviewed the subcommittee's report, the Committee met in October 1974 and prepared the Report of Safety and Efficacy of the Dalkon Shield and other IUDs. The Committee recommended continuation of the moratorium on the Dalkon Shield, based on the following observations:

(1) A notable number of deaths in association with pregnancy as well as a number of infected pregnancies.

(2) The electron microscopic observation of bacteria between the filaments of the multifilament threads of Dalkon Shields removed from women.

On January 17, 1975, the A.H. Robins Company voluntarily withdrew the Dalkon Shield from the market. Subsequently, the Company announced its decision to discontinue marketing of the Shield.

In addition to evaluating the safety and efficacy of the Dalkon Shield, the Committee approved a joint FDA-NICHD IUD Research Program. The Committee also endorsed the concept of professional and patient labeling of IUDs to ensure that physicians and patients are fully informed on the safety and efficacy of both drug and non-drug IUDs. Proposed FDA physician and patient labelings were published in the Federal Register on July 1, 1975.

While there is an abundance of scientific literature and research on drug and non-drug IUDs, it is largely uncoordinated and of limited practical value to those who insert IUDs. Therefore, the FDA contracted with the Battelle Human Research Center to assist in updating the 1968 FDA "Report on Intrauterine Contraceptive Devices." Based on a comprehensive review and analysis of the scientific and clinical data, the updated report represents an attempt to: (1) Identify clinical studies in which there is valid evidence of the effectiveness of both drug and non-drug IUDs, (2) Identify any hazards associated with drug and non-drug IUDs, (3) Identify any physiological and histochemical effects produced by IUDs other than contraceptive effects, (4) Identify the mode of action by which the contraceptive effects are produced, (5) Identify criteria and procedures for use in the selection and insertion of IUDs, and (6) Identify the nature of the information which should be made available to physicians and patients. The contract report was submitted to FDA on August 11, 1975. The two FDA Obstetrical-Gynecological Advisory Committees, drug and device, will draft the FDA 1975 IUD Report using the Battelle Contract report and the proposed FDA physician and patient labeling as source documents.

In anticipation of the passage of pending federal medical device legislation, the Panel on Review of Obstetrical and Gynecological Devices has classified all Obstetric and Gynecologic devices into three proposed regulatory categories: (1) Devices which should be subject to pre-market approval, (2) Devices for which standards should be set and enforced to assure safety and reliability, and (3) Devices which should be exempt from standard setting and pre-market approval but subject to certain general controls. The Panel has classified the non-drug intrauterine contraceptive devices in the pre-market approval category. The Panel has also prepared proposed guidelines for a clinical prospective study for non-drug intrauterine contraceptive devices.

The FDA is becoming increasingly concerned that additional surveillance may be needed for all IUDs, even when substantial evidence of short-term safety and effectiveness is submitted before marketing. Complete data, such as long-term or rare adverse events cannot be accumulated for the IUDs until after the IUDs are sold on a broad scale or have been used for some time. The FDA is actively exploring possible systems for post-marketing surveillance.

Health Services Administration

The Health Services Administration (HSA) is the major administrative support agency for Federal programs of subsidized family planning services. In the HSA, family planning services are provided by the Bureau of Community Health Services (BCHS), the Indian Health Service (IHS), and the Bureau of Medical Services (BMS).

Review and approval of services project grant applications is carried out in the DHEW Regional Offices. Regional Family Planning Program Consultants serve as coordinators for family planning within the Regional Offices.

The Bureau of Community Health Services administers programs under two major legislative authorities: the "Family Planning Services and Population Research Act of 1970" (PL 91-572), which established Title X of the Public Health Service Act and was subsequently amended by PL 93-45 and PL 94-63; and Title V of the Social Security Act as amended by the "Child Health Act of 1967" (PL 90-248) and the "Public Debt Limitation Act of 1973" (PL 93-53).

Title X of the Public Health Service (PHS) Act authorizes project grants to family planning services providers, grants and contracts for training family planning services personnel, grants and contracts for services delivery improvement research, and grants and contracts for the development and distribution of family planning information. Categorical project grants under PHS Act Title X represent the major Federal source of direct funding for family planning services.

Title V of the Social Security Act (SSA) authorizes maternal and child health formula grants to assist States in extending and improving their services for promoting the health of mothers and children, especially in rural areas and areas suffering from severe economic distress. PL 90-248 specifies that not less than six percent of the annual appropriations under SSA Title V must be available for family planning services.

The broad purposes of the Title X program include:

1. To assist in making comprehensive voluntary family planning services readily available to all persons desiring such services;
2. To improve administrative and operational supervision of family planning services;
3. To enable public and non-profit private entities to plan and develop comprehensive programs for family planning services;
4. To develop and make readily available information (including information materials) on family planning to all persons desiring such information;
5. To evaluate and improve the effectiveness of family planning service programs; and
6. To assist in providing trained manpower needed to effectively carry out family planning programs.

Public Health Service Act Title X

Title X of the PHS Act authorizes funds for family planning service projects, training grants and contracts, information and education activities, and services delivery improvement research.

Project Grants

Through 226 grantees, the family planning project grant program currently provides services to approximately 2,200,000 persons at 3,600 service sites. Services provided include comprehensive family planning medical, educational and social services (including health screening tests for cancer, anemia, and venereal disease; patient counseling; and the provision of contraceptive services).

Efforts begun in earlier years to improve project efficiency and productivity and upgrade the quality of services provided will continue during fiscal year 1976 with the introduction of ambulatory health care standards, medical audits, and cost reporting requirements which will assure funding decisions are made on a uniform basis. A technical assistance program will be conducted to assist projects in the implementation of findings from these management improvement efforts. The potential to collect additional third party reimbursements, however, is expected to level off during fiscal year 1976 primarily as a result of the change from SSA Title IV-A to SSA Title XX.

In fiscal year 1977 the program will continue to provide quality family planning services to as many individuals as possible in the most cost effective manner.

PL 94-63 will be implemented during fiscal years 1976 and 1977. Primary requirements of the law (which amended and extended PHS Title X) which will impact on its implementation are: economic status is not to be a barrier to participation in the program; individual grantees (as opposed to State and local consolidated grants) have a protected right to apply for and receive direct grants and contracts; and new grants may not be made for less than 90 percent of project costs while continuation grants may not be made for a percentage of project costs less than previously provided. New program regulations will be developed consonant with these requirements.

Training

The training focus in fiscal years 1976 and 1977 will be on improving the skills of staff delivering family planning medical services. Nineteen training grants and contracts have been awarded, and approximately 6,250 personnel will be trained in fiscal year 1976. These include physicians, nurses, nurse practitioners, health educators, project administrators, outreach and clinic aides. Increasing the number of nurse practitioners trained, addressing the maldistribution of health manpower, and identifying strategies to improve the skills of service deliverers in rural areas will be priorities of the training program in fiscal year 1977.

Information and Education

Efforts have been directed to informing the general public and potential consumers of the benefits of comprehensive family planning services, and to developing provider and patient oriented educational programs and materials. The fiscal year 1976 program will be directed primarily to high risk and hard-to-reach populations and will include model programs for delivering educational services to the mentally retarded and to teenagers in a school system setting. Special studies of informed consent education and the impact on patients' choice of methods will also be initiated.

The fiscal year 1977 program will continue to focus on the high risk and hard-to-reach populations, with special emphasis on teenagers. Informed consent educational materials for teenagers will be developed as well as other initiatives such as a model patient education program and a national clearinghouse for information and educational materials.

Services Delivery Improvement

The purpose of the services delivery improvement research program is to develop more effective and efficient methods and techniques for delivering family planning services, including technical assistance and the development of management tools. Special studies and programs are carried out to support the continued development and improvement of a national family planning program responsive to patient needs, to family planning priorities, to significant Regional, State and local variations, and to special population groups.

In fiscal year 1976 the services delivery improvement strategy will continue to stress the development and implementation of more effective methods of delivering services and managing family planning programs. The DHEW Region I (Boston) data system, which was expanded to incorporate an automated billing system to assist in collecting third party reimbursements, will be tested and implemented in other areas. Other activities will include the development of clinic management tools, including self instruction staff materials to assist family planning managers in improving clinic operations. Projects will receive technical assistance in implementing findings from previous studies and demonstrations.

The fiscal year 1977 program will include an assessment of family planning manpower development and utilization and implementation of external and internal audits to evaluate patient and project management. The possibility of including nutrition counseling as a component of patient education services will be investigated.

Social Security Act Title V

Under Maternal and Child Health formula grants, States are assisted in extending and improving their services for the promotion of the health of mothers and children, especially in rural areas. The States have broad discretion in the use of these funds, but the Maternal and Child Health's health service programs are generally preventive in orientation. The Crippled Children's programs provide diagnostic and treatment services.

Effective June 30, 1974, Social Security Act Title V project grants were folded into formula grants, as provided by law. Under Maternal and Child Health formula grants, States provide family planning services as a part of their programs of projects requirement to develop programs in each of five categories, including family planning. As of December 31, 1975, all States were in compliance and had at least one family planning project.

As a condition of State plan approval, the plan for Maternal and Child Health services must provide for the development of demonstration projects with special attention to family planning services for mothers in low-income areas and among groups in special need. Acceptance of family planning services must be voluntary and must not be a prerequisite of eligibility for the receipt of services under the plan. The 1967 Amendments to the Social Security Act further require a State to make a satisfactory showing that it is extending the provision of services under its plan, including family planning services.

Table 3, based on reports submitted by the States, shows the number of women receiving family planning services through State programs supported in part by Maternal and Child Health Formula Grants. Table 4 shows the number served in Maternity and Infant Care Projects for fiscal years 1971 through 1974. The States reported that SSA Title V Maternal and Child Health Formula Grants helped support family planning services for 1,115,749 individuals during fiscal year 1974, while the Maternity and Infant Care Projects served 103,290. Insufficient data are available for providing comparable figures for fiscal year 1975.

Nurse training programs conducted under Maternal and Child Health activities included family planning components. BCHS supports long-and short-term training programs for a variety of health professionals in the form of grants and technical consultation. All graduate nursing programs receiving support offer theoretical content and clinical practice in family planning.

Nurse-midwifery programs have a major family planning component integrated into both their classroom work and their clinical practice. The following table identifies these programs:

	Program Length	Number of Students Supported by MCH	Degree
University of Mississippi	12 months	20	Certificate
Columbia University	12 months	16	M.S.
Johns Hopkins University	24 months	14	M.P.H.
University of Utah	24 months	18	M.S.
State of University of New York	5 months (internship)	12	None
University of Illinois	24 months	6	M.S.

The following examples illustrate the types of activities conducted by some of these programs:

At Columbia University, nurse-midwifery students are given experience in inserting and removing IUDs, fitting diaphragms, dispensing oral contraceptives,

TABLE 3

Number of Women Provided Family Planning Services Under State Programs of Maternal and Child Health Fiscal Years 1974, 1973, 1972 and 1971

	1974	1973	1972	1971
Total	1,115,749	1,107,721	1,052,643[1]	763,234
Region I	14,791	15,918	12,000[2]	3,900
Connecticut	--	--	--	--
Maine	--	1,300**	12,000[2]	3,900
Massachusetts	--	--	--	--
New Hampshire	--	--	--	--
Rhode Island	14,791	14,618	--	--
Vermont	--	--	--	--
Region II	0	0	10,010[3]	10,034
New Jersey	--	--	--	--
New York	--	--	9,646[3]	10,034
Puerto Rico	--	--	364	--
Virgin Islands	--	--	--	--
Region III	100,950	163,761	66,075[4]	68,516
Delaware	--	9,223	7,440	5,676
District of Columbia	--	--	--	--
Maryland	8,700	44,783	8,693[4]	4,816
Pennsylvania	8,500	6,332	--	--
Virginia	65,275	90,000*	39,946[5]	51,528
West Virginia	18,475	13,423	9,996	6,496
Region IV	524,514	444,776	507,988	341,004
Alabama	38,012	21,227	62,528	50,669
Florida	107,793	104,348	98,077	67,704
Georgia	102,358	98,307	88,628	75,799
Kentucky	3,494	28,401	49,168	17,170
Mississippi	37,400	32,711	30,156	22,095
North Carolina	82,292	55,089	48,644	35,081
South Carolina	55,975	38,399	32,554	--
Tennessee	97,190	66,244	98,233	72,486
Region V	63,144	89,244	116,059[6]	85,022
Illinois	3,557	3,700*	6,623[5][6]	5,997
Indiana	16,447	12,734	10,525	5,127
Michigan	4,835	28,770	29,374[7]	9,654
Minnesota	--	3,170	--	1,300
Ohio	15,504	38,059[12]	76,904[8]	62,944
Wisconsin	2,802	2,791	1,633	--
Region VI	71,287	103,797	102,059	68,102
Arkansas	19,100	23,783	19,114	15,066
Louisiana	--	--	--	--
New Mexico	5,187	4,650	--	3,260
Oklahoma	--	--	35,850[9]	17,645
Texas	47,000	75,354	47,095	32,131
Region VII	100,836	68,120	41,609	33,466
Iowa	--	2,177	--	--
Kansas	25,283	24,182	--	8,300
Missouri	75,553	41,630	41,421	25,166
Nebraska	--	131	188	--
Region VIII	7,431	15,317	10,338	4,962
Colorado	--	7,321	4,761	1,242
Montana	--	--	--	1,893
North Dakota	--	1,583[5]	--	549
South Dakota	1,568	1,196	1,093	--
Utah	5,337	4,523	4,219	963
Wyoming	526	696	265	315
Region IX	217,904	168,686	150,060	108,461
American Samoa	--	--	--	--
Arizona	40,184	25,369	25,629	11,804
California	177,720	138,826	121,074[10]	93,931
Guam	--	--	--	--
Hawaii	607	607	390	--
Nevada	--	3,884	2,967	2,726
Trust Territories	--	--	--	--
Region X	34,892	38,152	36,445	39,767
Alaska	--	--	--	892
Idaho	2,418	2,757	1,746	920
Oregon	32,474	35,305	28,979	6,275
Washington	--	90	5,720[11]	31,660

Footnotes Table 3

*Estimated from Visits
**Estimated from Expenditure Data
1/Includes Chicago, Ill., 36 Local Health Departments in Massachusetts, New York City, N.Y., and Baltimore, Md.
2/Excludes Data from 36 Local Health Departments
3/Excludes New York City
4/Excludes Baltimore City, Md.
5/Estimated
6/Excludes Chicago Board of Health
7/Estimated from Report of New Patient and Return Visits
8/Data not Available from 10 Local Health Departments
9/Data not Available from two Counties
10/Incomplete Reporting
11/Data not Available for 4 Local Health Departments
12/Data for Year Ending Dec. 31

TABLE 4

Number of Women Provided Family Planning Services in Maternity and Infant Care Projects Fiscal Years 1974, 1973, 1972 and 1971

Total - U. S. Region and State	1974	1973	1972	1971
TOTAL	103,290	118,315	124,892	134,685
Region I	1,227	3,575	5,643	4,941
Connecticut	777	952	1,091	1,150
Maine	233	143	6	-
Massachusetts	149	1,726	3,855	3,328
New Hampshire	-	-	-	-
Rhode Island	68	754	691	463
Vermont	-	-	-	-
Region II	17,142	18,804	20,201	21,857
New Jersey	1,520	1,089	449	622
New York	13,805	16,151	18,094	19,143
Puerto Rico	1,593	1,564	1,658	2,092
Virgin Islands	-	-	-	-
Region III	12,369	15,145	16,960	19,553
Delaware	-	-	-	-
Dist. of Columbia	7,343	7,397	7,855	5,615
Maryland	1,237	1,322	2,076	6,939
Pennsylvania	-	3,596	4,385	4,218
Virginia	1,000	1,093	1,090	1,245
West Virginia	1,398	1,537	1,553	1,536
Region IV	37,148	43,590	42,198	35,244
Alabama	5,472	4,500	4,497	2,995
Florida	16,414	16,004	15,637	12,580
Georgia	10,009	17,505	16,405	14,631
Kentucky	439	431	558	552
Mississippi	868	932	849	815
North Carolina	1,480	1,434	1,380	1,185
South Carolina	2,486	2,706	2,672	2,483
Tennessee	-	-	-	-
Region V	10,741	12,592	15,189	28,532
Illinois	4,458	3,883	6,173	18,474
Indiana	111	141	13	-
Michigan	1,019	3,299	3,028	2,858
Minnesota	965	850	827	1,747
Ohio	4,208	4,419	5,148	5,453
Wisconsin	-	-	-	-
Region VI	15,017	15,117	12,812	13,603
Arkansas	1,125	1,345	2,233	2,316
Louisiana	-	-	-	-
New Mexico	1,783	1,499	1,048	920
Oklahoma	-	-	-	-
Texas	10,809	12,273	9,531	10,367
Region VII	1,300	2,470	4,147	3,767
Iowa	-	-	-	-
Kansas	-	-	-	-
Missouri	624	1,838	2,555	2,412
Nebraska	676	632	1,592	1,355
Region VIII	6,959	4,817	4,858	4,713
Colorado	6,959	4,817	4,858	4,713
Montana	-	-	-	-
North Dakota	-	-	-	-
South Dakota	-	-	-	-
Utah	-	-	-	-
Wyoming	-	-	-	-
Region IX	498	804	750	679
American Samoa	-	-	-	-
Arizona	-	-	-	-
California	163	176	249	252
Guam	-	-	-	-
Hawaii	320	484	501	427
Nevada	15	[illegible]	-	-
Trust Territories	-	-	-	-
Region X	909	921	2,136	1,696
Alaska	-	-	-	-
Idaho	272	190	146	157
Oregon	139	355	462	338
Washington	498	376	1,528	1,201

and in providing individual and group counseling. Because this group of nurse-midwifery students manages a maternity clinic for adolescents, they have an additional opportunity to initiate family planning with young people.

Some nurse-midwifery students at the State University of New York gave high priority to family planning and elected a block experience in the Family Planning Service of Kings County Hospital of Downstate Medical Center. Interns in the program felt that family planning comprised an important aspect of comprehensive maternity care. Most job requirements include responsibility for this area of care.

Maternal and Child Health supported University Affiliated Facilities, which offer multi-disciplinary training in the provision of services to the mentally retarded, provide training to meet the special family planning needs of the retarded. The primary emphasis is on teaching them responsibility for their sexual activity. The Institute for the Study of Mental Retardation and Related Disabilities at the University of Michigan, the Eunice Kennedy Shriver Center for Mental Retardation at the Walter E. Fernald State School in Waltham, Massachusetts, and the John F. Kennedy Child Development Center at the University of Colorado are among those University Affiliated Facilities which offer their social work and nursing students background on the rights of retarded adults, as well as specific knowledge of physiology, venereal disease, and contraceptives which can be used to counsel retarded individuals.

Related Family Planning Activities in the Bureau of Community Health Services

While the remaining BCHS programs do not have a primary focus on family planning, they encourage the integration of family planning activities within the range of health services which they offer.

Community Health Centers (authorized under Section 330 of the PHS Act) foster the delivery of family-oriented health services, including family planning, to approximately 1,872,000 persons. These centers are generally located in areas with a high concentration of urban and rural poor, areas where many persons desiring family planning services are likely to reside.

Migrant and seasonal farmworkers and their families are provided access to health care services at 355 service sites which are supported through 105 migrant health grants (authorized under PHS Act, Section 319). Some of the sites include family planning among the range of services provided.

Formula Grants to States for Public Health Services (authorized under PHS Act, Section 314(d)) assist the States in establishing and maintaining adequate public health services in accord with State-established priorities. Many States have used the flexibility of these grants to support family planning services.

The National Health Service Corps (authorized under PHS Act, Section 329) currently has 701 health professionals assigned in 340 communities which were previously "critically short" of health manpower. Family planning services are among the services provided to persons residing in these communities. The integration of Corps staff and resources with other programs, through the Rural Health Initiative, improves the overall Federal health delivery effectiveness and efficiency in rural areas. Family planning activities will be strengthened as a result of this approach.

The Indian Health Service of the Health Services Administration provides comprehensive health services, including family planning, to American Indians and Alaskan natives under PL 83-568. The Indian Health Service has been active in the field of family planning since fiscal year 1965. From that time through June 30, 1975, family planning services have been provided to an estimated 65,200 women. In fiscal year 1975, there were 48,400 medical visits by 26,300 Indian and Alaskan native women for family planning services. In fiscal year 1975, the number of Indian women 15-44 years of age was estimated at 99,900.

The Bureau of Medical Services provides family planning services in conjunction with the health programs administered by two of its component divisions, namely, the Division of Hospitals and Clinics and the Division of Federal Employee Health. By authority of the Public Health Service Act, (PL 410, 78th Congress, 58 Stat. 683, 1944), as amended, particularly by Sections 321-346, and the Dependents Medical Care Act and its amendments (PL 84-569), PHS beneficiaries are provided with comprehensive inpatient and outpatient medical services. Family planning services are included in these programs. Family planning information and counselling is provided to Federal employees through the Federal Employee Health Program authorized by PL 79-658.

Comprehensive family planning services provided by the Division of Hospitals and Clinics include the prescription and provision of pharmaceutical preparations, oral contraceptives, mechanical devices, surgical sterilization, and counselling. All postpartum patients are offered family planning information and services as part of the follow-up medical care at the Public Health Service Hospital in New Orleans which has the only obstetrical service within the Bureau of Medical Services. All U.S. Public Health Service hospitals and outpatient clinics provide family planning services upon request. There were an estimated 9631 visits to family planning clinics of the Division of Hospitals and Clinics during 1975. Community oriented family planning services are provided at the Boston Public Health Service Hospital through an agreement with the Massachusetts State Department of Health. The Staten Island Public Health Service Hospital provides outpatient and inpatient medical services for clients of the Family Planning and Health Clinic of the Staten Island Community Corporation.

The Division of Federal Employee Health, through the health unit operations, provides the following family planning education and counselling services upon request:

1. Family planning literature

2. Access to a physician and/or nurse to discuss family planning

3. Referral to public and private health care facilities for family planning services

Center for Disease Control

The Center for Disease Control (CDC) provides training to Epidemic Intelligence Service (EIS) Officers of the U. S. Public Health Service. Some individuals in the EIS program as well as other CDC career staff are trained in an epidemiologic approach to evaluating family planning and population programs. The Family Planning Evaluation Division, CDC, provides evaluation assistance to the Bureau of Community Health Services of the Health Services Administration, HEW Regional Family Planning Program Consultants, and to State, local and international health agencies (under an agreement with AID) in the evaluation of family planning programs. EIS officers and/or Public Health Advisors (PHAs) are assigned in Georgia, New York, Maryland, and California to improve and maintain data processing systems for family planning service statistics, to analyze contraceptive use effectiveness, and to conduct special studies and analyses based on the above aspects. In addition to these continuing assignments, short-term assistance is given to family planning programs for improving program management, designing and/or improving service statistics systems, conducting cost analyses, and evaluating family planning program performance.

Induced abortion has emerged as one of the most frequent surgical procedures in the United States today. To assist in eradicating preventable abortion-related maternal mortality and minimizing morbidity, CDC maintains surveillance of abortion, encompassing the following four general functions: (1) compilation of national abortion statistics, (2) investigation of all abortion-related maternal deaths, (3) study of early medical complications of abortion, and (4) performance of special studies and provision of technical assistance. First, in collaboration with individual States, CDC collects both demographic and technical information on patients obtaining abortion. As the legal status of abortion has changed, the national total has expanded from approximately 22,000 reported abortions in 1969 to 755,207 in 1974. CDC publishes a statistical analysis of reported abortions in its annual Abortion Surveillance Report. The second major activity in abortion surveillance is the monitoring of all maternal deaths related to abortion. The number of deaths has declined from 132 in 1969 to 47 in 1974. CDC investigates each case to ascertain risk factors and elements of preventability, and it disseminates these findings through national meetings and publications. The third major activity in abortion surveillance is the administration of the Joint Program for the Study of Abortion/CDC (JPSA/CDC), a prospective multicenter study of early complications of abortion. Including reports of over 80,000 abortions between 1971 and 1975, JPSA/CDC represents the largest abortion study to date. Analysis of JPSA/CDC is underway, and an anticipated series of publications from this work will update existing knowledge of abortion morbidity and the potential for its prevention. Finally, the fourth major activity involves conducting special studies and providing technical assistance related to abortion at the request of State and local health officials. A recently undertaken study will identify the factors involved in women's delay in obtaining abortion. Through these four abortion surveillance activities, CDC strives to minimize the risks to the increasing numbers of women seeking abortion each year. Since 1972, CDC has directly assisted the States of New York, Arkansas, Kansas, and New Jersey as well as the cities of New York, Dallas, Philadelphia, Buffalo, Chicago, and Portland (Oregon) with abortion-related health problems.

Epidemiologic field investigations of the medical consequences of drugs, devices, and techniques employed in family planning programs are being conducted. A major study of the association of oral contraceptive use and the development of breast diseases (both benign and malignant) has been completed. The results showed that women who used oral contraceptives for more than two years were about half as likely to develop benign breast disease as women who never used that medication. In addition, there was no unusually high frequency of breast cancer in oral contraceptive users. Further studies of the possible association of oral contraceptive use and breast cancer are planned. Because surgical sterilization is the most rapidly growing form of contraception in the United States, a major portion of time has been devoted to identifying existing data concerning the morbidity and mortality rates associated with various surgical sterilization procedures. These morbidity and mortality rates will be analyzed in fiscal year 1976. At the request of the Food and Drug Administration, CDC designed a nationwide study of the possible association of oral contraceptive use and certain benign liver tumors that have a high case fatality rate. Implementation of this project is pending OMB clearance.

Health Resources Administration

The National Center for Health Statistics (NCHS) derives its authority in population from the general data collection and research provisions of Sections 304 and 306 of the Public Health Service Act, and from the transfer of certain functions relating to vital statistics from the Census Bureau to the Public Health Service. NCHS is responsible for collecting and analyzing the wide range of health and demographic statistics needed for health planning and program evaluation.

The NCHS collects, analyzes, and publishes national vital statistics on live births, deaths, fetal deaths, marriages, and divorces or dissolutions of marriages. It also conducts research on the dynamics of population change associated with these vital events and examines some of the relevant socioeconomic factors. Under an agreement with the Center for Disease Control, the NCHS is establishing a national abortion reporting system in which it will receive data on abortions from all States meeting NCHS reporting standards.

The NCHS conducts periodic vital records followback surveys based upon samples of births and deaths reported in the registration system. These surveys are designed primarily to expand the scope of data beyond that which can be routinely collected from the birth and death records. In the birth and infant death followback surveys, the respondents have included the mother, the attending physician, and the health facility where the baby was born. Data have been collected on such topics as the mother's marital, pregnancy, and employment history; whether the most recent pregnancy was wanted; the mother's expectations of additional births; sterilization procedures following the birth of the last child; maternal and infant health care; and income.

The NCHS has recently established a biennial National Survey of Family Growth to collect data on factors affecting trends and differentials in the birth rate, family planning, and infant and maternal health. This survey is based upon personal interviews with representative samples of ever-married women in the childbearing ages. Data from the first biennial cycle of the National Survey of Family Growth will be released in 1976. Data for the second cycle will be collected early in 1976 and will represent the U.S. contribution to the World Fertility Survey Program.

NCHS and the Research Triangle Institute in North Carolina have collaborated in the development of a computer model intended to simulate the dynamics of population growth. A manual has been prepared and disseminated to enable others, within this country and abroad, to apply the model to their own population structure and problems.

NCHS is responsible for operating a uniform national family planning services reporting system. This reporting system was developed in two stages. NCHS worked with governmental and private family planning groups to initiate a provisional family planning reporting system. This provisional system provided data on the utilization of family planning services which were financed at least in part by Federal funds, and for which there was an immediate program need for data.

Based on the experience gained from operating the provisional system, NCHS developed the National Reporting System for Family Planning Services (NRSFPS) for use by all Federally-supported family planning programs, clinics, and service points, and by other agencies wishing to participate in the reporting system. The NRSFPS currently provides monthly, quarterly, and annual reports essential for the efficient and effective development, operation, and evaluation of family planning programs throughout the Nation.

A second NCHS program for providing information on family planning services (The National Inventory of Family Planning Services) was initiated in 1974. The National Inventory is a comprehensive listing of all sites in the United States that provide family planning services, whether these services are medical or non-medical. Periodic censuses of the Inventory provide basic data on each facility, including information on staffing and services offered. The Inventory is also expected to provide the base for special sample studies from which additional, more detailed information can be acquired.

IV

SOCIAL AND REHABILITATION SERVICE

Public Services Administration

Family planning services are included in the Social Services Program authorized under Titles I, IV, X, XIV, XVI, and XX of the Social Security Act (SSA). Administration of these programs is in the Public Services Administration.

Family planning services include the provision of information, personal counseling, medical services, payment for medical services, referral for medical care, follow-up of medical referrals, provision for transportation and child care arrangements so that parents may obtain medical care, and the development of medical resources when none exist.

The Social Security Amendments of 1967 (PL 90-248) required that under SSA Title IV-A, family planning services were to be offered in all appropriate cases. Acceptance of such services was to be voluntary and was not to be a prerequisite for or impediment to eligibility for the receipt of any other service or financial aid.

The Social Security Amendments of 1972 (PL 92-603) provided significant new incentives for the provision of family planning services. This Act makes the informing of the availability and the prompt provision of family planning services mandatory to all present recipients of Aid to Families with Dependent Children (AFDC) who are of childbearing age and imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Social Services from 75 percent to 90 percent.

The Social Services Amendments of 1974 (PL 93-647) added a Title XX to the Social Security Act. Under Title XX the three major provisions of PL 92-603 continue in effect: (1) Family planning services must be offered and provided promptly upon request to all AFDC recipients, (2) States are penalized one percent of the Federal share of their AFDC funds for failure to provide family planning services to eligible persons desiring them, and (3) The Federal share of matching for family planning services under Title XX continues at the 90 percent rate. States may also elect to provide family planning services to individuals whose family monthly gross incomes are less than 115 percent (or, at State option, a lower percentage) of the median income of a family of four in the State, adjusted for family size. States may charge a fee for services to AFDC recipients or to individuals whose family monthly gross incomes are less than 80 percent of the median income of a family of four in the State, adjusted for family size, or the median income for a family of four in all States, adjusted for family size, whichever is less. However, such fees must be consistent with regulations issued by the Secretary of DHEW. The imposition of a fee reasonably related to income is mandatory for those individuals with incomes between the 80 and 115 percent levels. In addition, States may elect to provide family planning services to recipients of Supplementary Security Income (SSI) as one of the three mandated services to this group under Title XX.

Medical Services Administration

The Social Security Amendments of 1965 (P.L. 89-97-- approved July 5, 1965) added Title XIX, "Grants to States for Medical Assistance" to the Social Security Act. Under the Federal-State medical assistance program which it established, known as Medicaid, States participating in the program were required to provide medical assistance to all recipients of cash assistance. At State option, they could also finance medical care for the medically needy, i.e., those persons who would otherwise be eligible for cash assistance except that the level of their income is sufficient to sustain themselves, but too low to provide necessary medical care. In addition, States could opt to provide coverage to children under 21 from low-income families.

Under the original legislation, inclusion of family planning services was a State option. However, P.L. 92-603, passed in October 1972, made coverage of family planning services for cash assistance recipients under Title XIX mandatory on the States. In addition, the rate of Federal financial participation for family planning services for both the categorically and medically needy was increased to 90 percent on the date of enactment of the Bill.

Medical assistance for family planning includes payments for appropriate medical examinations, diagnosis, medical counseling and treatment, laboratory services, surgical procedures, drugs, supplies and devices. These services may be provided in doctors' offices, clinics, hospitals (on both an inpatient and outpatient basis), family planning centers, or any other suitable settings.

Because of the increased responsibilities placed on the State agencies to assure that family planning services are offered and available to all eligible persons who wish to utilize them and the increased Federal matching, a sizeable increase has occurred in Title XIX expenditures for family planning from FY'72 through FY'75.

V

EDUCATION DIVISION

Office of Education

The Office of Education (OE), through its various grant programs, enables educational institutions at all levels to include family life, sex education, and support for innovative family-related projects in their programs. All decisions concerning curriculum, teaching methods, qualifications of teachers, and classroom materials are made by State and local authorities acting within the framework of State law.

Elementary and Secondary Education

The Elementary and Secondary Education Act of 1965 (PL 89-10) and its amendments provide several titles under which family life and sex education activities are eligible for support.

Title I, Grants for the Disadvantaged, assists in expanding and improving educational programs aimed at meeting the special needs of educationally deprived children from low-income families, handicapped children, delinquent or neglected children, and migrant children. Further payments are made to the Secretary of the Interior for grants to benefit Indian children in Federal schools administered by the Bureau of Indian Affairs as well as out-of-State Indian children in elementary and secondary schools. Recipients of Title I grants may use the funds for projects relating to dropouts, pre-schoolers, teen-age unwed mothers, and other approaches for remedying education deprivation. However, the components of these projects which are concerned with family life and sex education are not identifiable per se.

The purpose of ESEA Title III, Supplementary Educational Centers and Services, is: to enable schools to provide programs currently unavailable to children; to improve educational services already offered; and to stimulate the development and evaluation of experimental elementary and secondary educational programs which can serve as models. Fifteen percent of program funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing. Although not dealing directly with family life and sex education, Title III projects in environmental education provide information on population environmental affairs.

Originally, the Commissioner of Education made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were to be administered by State education agencies, with fifteen percent to be used at the Commissioner's discretion within the State.

The Dropout Prevention program, Title VIII, Section 807 of the Elementary and Secondary Education Act, has no family planning projects as such. However, several projects for pregnant women in fiscal year 1974 included components related to family planning such as pre- and post-natal care, personal counseling, and child care. Under this program, funds are used to support demonstration projects designed to reduce the number of dropouts in low-income areas and in areas where a high percentage of children do not complete their elementary or secondary school education. Since pregnancy and/or early marriage constitute the largest cause of dropout by teen-age girls, the need for inclusion of family life and sex education in a comprehensive school program is apparent.

Vocational Education

Under Grants to States for Vocational Education, the Consumer and Homemaking Education Program (PL 90-576, Part F) supports a number of projects with components relating to family life and child care.

For example:

--Family planning may be included in the study of family relationships, marriage, and child care offered in vocational home economics education courses for secondary and post-secondary students. Although some portion of instructional time is concerned with family planning, this activity cannot be identified per se. The decision to include a study of family planning in the home economics courses is made by the local community.

--Courses in child care/development which offer preparation for parenthood are being emphasized in consumer and homemaking education programs for both youth and adults. Enrollment in specialized courses on this subject increased from 4,038 in fiscal year 1966 to 172,984 in fiscal year 1974. Child development laboratories are part of the home economics facilities in most high schools in Montgomery County and Prince Georges County, Maryland. Full year courses in child development from the pre-natal stage through childhood are offered at these high schools for students, grades 10 to 12. National enrollment in family relations courses has expanded from 95,367 in fiscal year 1967 to 225,665 in fiscal year 1974, with an estimated enrollment of 250,000 in fiscal years 1975 and 1976.

Specific family planning and child care/development activities include:

--Teenage-parent programs, offered under the auspices of the home economics department in many schools, are now making it possible for young parents to continue in school. These education programs are providing specific assistance to expectant young parents in caring for their babies and assuming their future responsibilities.

--In one community, enrollment in courses in family living is required of family court clients. Attending these courses are single parents, parents of youth from poor socioeconomic areas, potential school dropouts, delinquents, unwed parents, and foster parents.

-- In cooperation with local public housing authorities, school districts in some major cities are providing Family Life Education programs for low-income families. Classroom space (one or two apartments), large equipment, and some supplies are made available by the housing authorities.

--The number of consumer and homemaking education programs in middle and junior high schools is growing rapidly. These programs focus on four areas: personal relationships, personal health, personal environment, and personal development.

--In Alburquerque, New Mexico, a special program in child development is being offered for 9th grade Spanish American girls in a school where the drop-out rate prior to the course was 40 percent. The drop-out rate at the school has been reduced substantially since the program's inception in 1970.

Adult Education

The Adult Education Program authorized by the Adult Education Act of 1966, as amended, (PL 91-230, Title III and PL 93-380), is designed to serve undereducated adults. All adults with less than a high school education are eligible; however, major emphasis is on adults with less than an 8th grade education. The program's primary objective is to enable the participating adults to become employable, productive, and responsible citizens as well as self-reliant and competent individuals, parents, and family members.

Through grants to State departments of education, matched by State and local funds, opportunities are provided in local communities for adults to improve their learning and communication skills - reading, speaking, writing - and their computation skills. Family-related concerns of participants, many of whom are parents and heads of families, are reflected in the curricula, and there is an increasing emphasis on home management, consumer education, nutrition, family development, family planning, and parent education. The "Family Development Series" of materials for Adult Education participants is widely used, as are other family-related materials.

Parent and family-related education is a major focus in the State adult education program in Utah and receives considerable emphasis in other States, particularly New York and Maryland. With a marked increase in home-based adult education, family-related content is receiving more emphasis in this setting. In Vermont, approximately half of the adult education program is home-based to reach the largely rural population.

In an increasing number of communities, the local adult education program provides classes for mothers of children in Head Start and Parent Child Centers. Activities are carried out in cooperation with Home Start and the Child and Family Resource Center models being developed by the Office of Child Development to serve children and their families.

Under Section 309 of the Adult Education Act, States are required to use not less than 15% for special projects and for training persons to work in adult education programs. Activities carried out under this provision include curriculum development, experiments with innovative delivery systems, cooperation with other agencies, and the establishment of competency-based personnel training. Family-related concerns are reflected in these activities; however, actual cost data on programs and projects involving family planning are not available.

At the Federal level, the National Advisory Council on Adult Education demonstrated its concern in the broad area of family-related education with emphasis on parent education by preparing a position paper on Roles and Responsibilities of Adult Education with Family/Parent/Early Childhood Education priority.

Higher Education

Title I of the Higher Education Act of 1965 (PL 89-329) provides financial support to encourage colleges and universities to assist in the solution of community problems through specially designed continuing education and community service programs. A State desiring to receive its allotment of Federal funds under this Title must designate or create a State Agency which is required to submit an annually amended State plan to the U.S. Commissioner of Education for approval. The plan must set forth administrative policies and procedures and identify community problems it wishes colleges and universities to address. The State Agency reviews proposals from institutions of higher education and awards funds to approved projects on a 66 2/3 percent Federal and 33 1/3 percent non-Federal matching basis. No funds have been released for Title I in fiscal year 1976, and there is no request for funding in fiscal year 1977. Of the $14,250,000 fiscal year 1975 appropriation for Title I, $287,000 was allocated for family planning activities under the Grants to States for Community Service and Continuing Education program.

VI

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
POPULATION RESEARCH AND FAMILY PLANNING ACTIVITIES

Obligations, FY 1973 -- FY 1977

Agency and Program	Fiscal Year 1973	1974	1975	1976(Est.)	1977(Est.)
Total, Department of Health, Education, and Welfare	$228,860,000	$321,216,000	$310,622,000	$333,142,000	$291,687,000
PUBLIC HEALTH SERVICE					
Office of the Assistant Secretary for Health					
Office of International Health					
Scientific Activities Overseas (Special Foreign Currency Program, P.L. 480)1/	909,000	342,000	124,400	716,000	194,000
National Institutes of Health					
National Institute of Child Health and Human Development	39,844,000	51,025,0002/	50,385,000	53,796,000	51,329,000
Health Services Administration					
Bureau of Community Health Services (BCHS)					
Maternal and Child Health					
Formula grants to States	$ 11,700,000	$ 11,700,000	$ 43,600,000	$ 47,037,000	$ 28,000,000
Project grants for maternity and infant care	4,500,000	4,500,000	---	---	---
Research	100,000	100,000	100,000	---	---
Family Planning	107,207,000	149,491,0003/	99,826,0004/	100,615,000	79,435,000
Subtotal, BCHS	123,507,000	165,791,000	143,526,000	147,652,000	107,435,000

1/ Not included in the PHS or DHEW total. All obligations are in U.S. - owned excess foreign currencies.
2/ Includes $6.2 million authorized under the FY 1973 continuing resolution, released for obligation in FY 1974.
3/ Includes $ 15 million previously administered by the Office of Economic Opportunity; also includes $30 million authorized under the FY 1973 continuing resolution, released for obligation in FY 1974.
4/ Includes $409,000 authorized under the FY 1973 continuing resolution, obligated in FY 1975.

Obligations, FY 1973 -- FY 1977 (Cont'd)

Agency and Program	Fiscal Year 1973	1974	1975	1976(Est.)	1977(Est.)
Indian Health Service	$ 896,000	$ 1,061,000	$ 1,237,000	$ 1,347,000	$ 1,476,000
Bureau of Medical Services	268,000	227,000	193,000	161,000	--- 5/
Subtotal, Health Services Administration	124,671,000	167,079,000	144,956,000	149,160,000	108,911,000
Center for Disease for Control	378,000	253,000	368,000	492,000	492,000
Health Resources Administration					
National Center for Health Statistics	461,000	791,000	937,000	1,081,000	3,530,000
Total, Public Health Service	$165,354,000	$219,148,000	$196,646,000	$204,529,000	$164,262,000
SOCIAL AND REHABILITATION SERVICE					
Social Services	38,872,000	34,547,000	43,177,000	49,678,000	52,800,000
Medical Assistance	18,200,000	52,434,000 6/	56,772,000	65,512,000	74,625,000
Total, Social and Rehabilitation Service	$ 57,072,000	$ 86,981,000	$ 99,949,000	$115,190,000	$127,425,000
EDUCATION DIVISION					
Office of Education					
Elementary and Secondary Education					
Grants for Disadvantaged (ESEA I)	7/	7/	7/	7/	7/
Support and Innovation Services	622,000 8/	302,000 8/	240,000 8/	151,000 8/	---

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5/ This reflects the Department's budget policy to close all Public Health Service General Hospitals and Outpatient Clinics in FY 1977.

6/ FY 1974 is the first year that actual expenditures for family planning were reported by the States. Obligations for years prior to FY 1974 are estimates.

7/ Funds expended for family-related activities which are components of larger projects cannot be separately identified. Allocations are made to the States on a formula basis, and States are not required to report the use of funds according to subject area.

8/ Totals shown for FY 1973 through FY 1975 were allocated under the Dropout Prevention and the Supplementary Education Centers and Services programs. In FY 1976, these funds will be consolidated under the Support and Innovation grants consolidation program.

Obligations, FY 1973 -- FY 1977 (Cont'd)

Agency and Program	Fiscal Year 1973	1974	1975	1976 (Est.)	1977 (Est.)
Occupational, Vocational, and Adult Education					
Grants to States for Vocational Education........	7/	7/	7/	7/	7/
Adult Education..................................	$ 5,613,000	$ 14,550,000	$ 13,500,000	$ 14,550,000	7/
Higher Education					
Grants to States for Community Service and Continuing Education...........................	199,000	235,000	287,000	---	---
Total, Education Division..................	$ 6,434,000	$ 15,087,000	$ 14,027,000	$ 14,701,000	7/

7/ Funds expended for family-related activities which are components of larger projects cannot be separately identified. Allocations are made to the States on a formula basis, and States are not required to report the use of funds according to subject area.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

REPORT ON HEARING AND SPEECH

A REPORT TO THE
HOUSE COMMITTEE ON APPROPRIATIONS

HEARING AND SPEECH

Obligations Fiscal Year 1973 to Fiscal Year 1977

Agency and Program	1973 5.9%	1974 5.9%	1975 5.7%	1976 5.7%	1977 5.5%
OFFICE OF HUMAN DEVELOPMENT					
Rehabilitation Services Administration:					
Basic State Grants..	$34,751,000	$38,350,000	$38,760,000	$38,760,000	$39,600,000
Service projects....	280,000	140,000	581,000	435,000	1,229,500
Rehabilitation training..........	3,767,067	270,800	2,671,717	2,805,000	2,500,000
Rehabilitation Research and demonstrations.........	1,000,000	250,000	180,000	180,000	250,000
Rehabilitation Research and training centers..	400,000	480,000	500,000	500,000	500,000
Special foreign currency program..	400,000	-	350,000	200,000	200,000
Total, RSA........	$40,598,067	$39,490,800	$43,042,717	$42,880,000	$44,279,500

HEARING AND SPEECH

Obligations Fiscal Year 1973 to Fiscal Year 1977

Agency and Program	1973	1974	1975	1976	1977
OFFICE OF EDUCATION:					
Elementary and secondary.......	$19,800,000	$15,200,000	$11,000,000	$11,600,000[1]	$11,700,000
Education for the handicapped.....	32,795,771	44,034,537	55,306,000	53,818,000	53,818,000
Occupational, vocational, and adult education.	4,883,200	3,800,000	3,800,000	1,000,000[4]	1,000,000
Library resources.	50,000	40,000	40,000	30,000	30,000
Research and Training.........	2/	---	---	---	---
National Advisory Committee on the Handicapped...3/	26,081	32,484	100,000	100,000	100,000
Subtotal, Office of Education....	$57,555,052	$63,107,021	$70,246,000	$66,548,000	$66,648,000
HEALTH SERVICES ADMINISTRATION:					
Community Health Services........	$ 3,970,500	$ 3,370,000	$ 2,810,000	$ 2,890,000	$ 2,890,000
NATIONAL INSTITUTES OF HEALTH:					
National Institute of Neurological Diseases and Stroke..........	$10,240,000	$12,164,000	$14,539,000	$16,644,000	$16,249,000
National Institute of Child Health and Human Development.....	11,752,000	15,612,000	15,453,000	15,401,000	14,373,000
National Institute of Dental Research........	1,774,053	2,385,227	1,694,281	1,699,816	1,700,000
National Institute of Environmental Health Sciences.	212,000	460,000	510,000	360,000	515,000
Subtotal, National Institutes of Health..........	$23,978,053	$30,621,227	$32,196,281	$34,104,816	$32,837,000
Subtotal, Public Health Service..	$27,948,553	$33,991,227	$35,006,281	$36,994,816	$35,727,000

HEARING AND SPEECH

Obligations Fiscal Year 1973 to Fiscal Year 1977

Agency and Program	1973	1974	1975	1976	1977
SPECIAL INSTITUTIONS:					
National Technical Institute for the Deaf.........	$ 7,223,000	$ 7,226,000	$ 10,748,000	$ 10,980,000	$ 14,547,000
Gallaudet College......	28,280,000	25,661,000	21,348,000	43,201,000	43,687,000
Subtotal, Office of the Secretary....	$ 35,503,000	$ 32,887,000	$ 32,096,000	$ 54,181,000	$ 58,234,000
TOTAL, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE........	$161,604,672	$169,476,048	$180,390,998	$200,603,816	$204,888,500

1/ The programs in these activities which supplied funds for hearing and speech are being consolidated, in fiscal year 1976, into a consolidated education grants program which specifies that 50% of the funds included in the consolidation must be used for the same purposes for which they were used previously. Beginning in 1977, total grant consolidation will be achieved.

NOTE: Of the activities reported from the Elementary and Secondary education appropriation, Title I is not in the consolidation; Title IV is.

2/ Program transferred to the National Institute of Education in fiscal year 1973.

3/ From 1972-1973, amounts are for the National Advisory Committee on Education of the Deaf; during 1974 this Committee combined functions with the National Advisory Committee on Handicapped Children to form a new National Advisory Committee on the Handicapped. This activity was previously reported under the Office of the Secretary.

4/ New legislation will be proposed for most of the programs involved. No estimates can be included for those activities.

OFFICE OF HUMAN DEVELOPMENT
REHABILITATION SERVICES ADMINISTRATION
SUMMARY OF PROGRAMS FOR THE DEAF, FOR THE HARD OF HEARING AND FOR THE SPEECH IMPAIRED

The Rehabilitation Act of 1973 is providing vocational rehabilitation with important new means to reach out and serve men and women with serious communicative disorders. While the history of vocational rehabilitation is replete with sucesses in service to individuals handicapped by deafness and hearing and speech impairments, it was not until this recent legislation that work with the most severely disabled could be initiated. Program development in the area of serious communicative disorders is now making it possible for heretofore unserved or underserved people to achieve their vocational rehabilitation potential.

A summary of the most outstanding ongoing and developing vocational rehabilitative activities that are anticipated to increase the number of deaf, hard of hearing and speech impaired persons rehabilitated annually are presented in this report.

The Problem in General

Americans who are vocationally handicapped by varying degrees and kinds of communication disorders exceed 20,000,000 in number. Some have disorders of the ears, the normal channels for receiving verbal messages. Some have defects in the vocal mechanisms, the main means for sending verbal messages. Some have disorders of the central nervous system which interfere with receiving and sending even though the ears and vocal apparatus are whole. Some have peripheral involvements that curb free verbalization. Some have combinations of causes.

The complexity and variety of the causes frequently obscure the fact that speech and hearing are variables that fluctuate with physical, mental and emotional conditions. Normal ears, normal mentality, normal vocal mechanisms and so on should result in normal hearing and normal speech. One abnormality or more results in abnormal communication. The person permanently affected faces formidable barriers. Fortunately, the condition for many is transitory due to the wonders of medicine and related disciplines. These are not among the above-named 20,000,000 whose disabilities are constant, who continuously search for ways to reduce the handicap of communication limitation.

Vocational rehabilitation workers share with teachers, audiologists, speech pathologists, medical workers, and others the responsibility to create, extend and improve knowledge and resources by which the communicatively handicapped can attain adjustments commensurate with their mental and residual physical capacities.

The Deaf

Our 1.8 million deaf people have very complex problems. Many of them are without useful speech despite years of training. Many have limited language skills. They receive messages principally through their eyes. They send message by combinations of signs, gestures, speech, and writing. Most of them have normal strength, mobility and intelligence. They strive for achievement within the limitations imposed by society. It is primarily a psychosocial problem. It manifests itself in many ways: underinvolvement in the main stream of community life; limited socializing with fellowmen; lack of acceptance among neighbors, employers and fellow employees; severe underemployment. It seldom yields at all to medical intervention such as drugs, surgery or prosthesis. It does yield in approximate ratio to the availability in quality and depth of training and adjustment services that stem from comprehensive, expert diagnosis that may involve the disciplines of psychology, audiology, medicine, and education and to public relations activities that stress the deaf person's strengths.

Two deep-seated problem areas for vocational rehabilitation exist with respect to deaf people. First, the most basic and achievable need of the deaf person, specifically skill in reading and writing, has until very recently been insufficiently emphasized in childhood training. Formal training has generally so heavily emphasized the development of speech skills in the deaf child that speech has erroneously assumed the position of being the equivalent of rather than a vehicle for language. To put it another way, teachers of the deaf have focused disproportionate time and energy upon an outlet (speech) for language rather than power in language itself. Language and speech have been referred to interchangeably, confusing professional and lay workers alike. Hence, the handicapping aspects of deafness have often been intensified by a needless wall of language deficiency. Developing interest in total communication (use of speech, fingerspelling, signs, gestures, reading and writing in combinations verbal by individual children) by parents and educators as a better means for early language development in deaf people is a promising new movement.

Second, an incorrect image of the deaf person's potential in verbal communication skills stems from this heavy emphasis on speech and frequently unrealistic publicity that generates from it. These together create everywhere an expectancy in oral communication performance which very few deaf people can fulfill. Employers and others are, thus, not conditioned to look beyond the poor speech for the hidden, often rich, human resources.

The Rehabilitation Services Administration is attacking the roots of underemployment: (1) By encouraging and assisting in the establishment of rehabilitation centers to diagnose and train deaf people: (2) by extending its training operations (a) to reduce the communication barrier facing deaf people by developing standards and new procedures for speech conservation, utilization of telecommunications, instruction in manual communication and interpreting, (b) to qualify more professional workers in psychology, social work, vocational rehabilitation, speech therapy and audiology to work with the deaf, (c) to develop better understanding of the potentials of deaf people among vocational rehabilitation workers and others, including employers and community leaders, (d) to improve the understanding among professional and voluntary workers of how they can assist the State vocational rehabilitation agencies in serving the deaf, and (e) to help deaf people and their co-workers develop more productive concepts of community inter-relationships; (3) by encouraging researchers to study and resolve the many economic, social, and psychological problems associated with deafness; (4) by extending assistance in the establishment of post secondary programs for deaf people; (5) by encouraging and assisting universities in opening new professional fields to deaf people through special programs and placement techniques; (6) by aiding parents to become more involved in the rehabilitation of their deaf children; and (7) by bringing into focus the needs and remedial actions that are unique to the civil rights of deaf people.

The Hard of Hearing

The several million hard of hearing pose quite different problems from the deaf, the two groups cannot be treated as one. Whereas the deaf receive verbal communication almost solely through their eyes, the hard of hearing rely principally upon their ears, even though these are defective. The hard of hearing generally have near-normal speech and language. Their disability often had a late onset as opposed to the early affliction of the deaf. Partial hearing impairment is less a psychosocial than a medical problem and often yields significantly and quickly to medical intervention and prosthesis with speedy return to an old job or a new one.

It is known that the number of individuals with partial hearing loss is far greater that those who have lost their hearing completely. How much greater is unknown. More accurate estimates are needed before the full magnitude and vocational significance of this problem can be assessed. Deteriorating job performance, eventual loss of job, and gradual withdrawal from family and society are three of the more obvious results of gradual and progressive hearing loss. Too few of these people request help from their State divisions of vocational rehabilitation.

The problems of the hard of hearing are many; this the State vocational rehabilitation counselor knows. How best to solve them, no one yet knows. Much remains to be accomplished in helping the hard of hearing person retain the skills he had before the onset of his handicap. Better diagnostic methods need to be developed to permit more successful fitting of hearing aids. Abilities which permit a person to speechread (lipread) successfully are, at present, unidentified. And yet, accurate prediction of such ability would have profound effects on the rehabilitation management of hard of hearing and deaf children as well as adults.

Further attention should also be given to ways of helping the person with progressive hearing loss retain his speech intelligibility while he is losing his major sensory pathway for judging the accuracy of his speech production.

Basic to meeting the vocational rehabilitation needs of our hard of hearing are people to provide the highly specialized services that they need and the places to do it. The Rehabilitation Services Administration is aggressively involved in helping the States to find these fundamental resources.

The Speech Impaired

The speech impaired, including the language impaired, necessarily include many of the deaf and the hard of hearing because normal speech production depends to a great extent upon self-monitoring which in turn depends largely upon the speaker's hearing. We hear ourselves and correct as we go along. It is not the same for the hearing disabled. However, there are also millions of speech impaired whose abnormal or absent output stems from organic disorders other than hearing.

The special needs of stroke victims, particularly those with language problems due to aphasia, have received nation-wide attention. Little is known about the actual incidence of the disability, particularly in its more subtle and partial forms. Also, diagnostic techniques to determine the most appropriate treatment program and the outlook for recovery remain crude and inexact. Unavailability of crucial specialized services within the aphasic's home community particularly language therapy, poses insurmountable problems for most aphasics living outside large metropolitan areas. New methods of extending services to those people and/or training other family members to assume the task must receive high priority. Programmed teaching machines represent one partial solution to this problem, but self-teaching programs must be developed and evaluated. The spotlight of attention given to this affliction merely highlights the problems which are as yet unsolved.

Equal attention has recently been given to cancer victims. In great need of rehabilitation are those who have lost their larynx because of cancer, thus, their ability to produce voice. Such a sudden handicap usually results in loss of job and loss of family responsibility. Training procedures now exist to help the laryngectomees learn to use esophageal speech, but too often those methods fail. Many individuals, therefore, go for the rest of their lives without the ability to speak. Reasons for this failure must be found. Better techniques for identifying those people who will be able to learn esophageal speech--and those who will not--are needed. Programmed learning methods also need to be considered as possible retraining procedures. Pre-surgery personality factors deserve investigation as probable reasons for post-surgery response to rehabilitation efforts.

Stuttering is another wide-spread speech handicap which deserves greater attention. Over 1,000,000 people in the United States suffer from this affliction. The problems of the adult stutterer are particularly damaging and cause the individual to lead a restricted and sterile life. This is true primarily because the speech defect is variable; the stutterer rarely knows when he begins to speak whether he will talk normally or will produce a spasm of muscular tension and an explosion of distorted words. Most stutterers, therefore, remain constantly "on guard" and resort to bizarre tricks and body motions (which themselves attract attention) to avoid stuttering. Some stutterers even pose as deaf to avoid having to speak. Consequently, many stutterers of superior ability accept jobs which require little or no talking and remain at a level of employment far below their aspirations and capacities. Underemployment, self-imposed, may sometimes be the stutterer's handicap.

Usually, these problems are most resistant to change, even though most of the stutterer's speech problem has been learned and can be unlearned. The reasons for the tenacity of stuttering are unknown. What is particularly puzzling is the fact that for a few persons, long-time stuttering can be eliminated with relative ease. Clinical observation has indicated that there are different types of stutterers. We need to find ways of identifying each kind and the critical factors which determine their response to rehabilitation. Also, better ways of helping stutterers achieve and retain more normal speech must be found. To do this, better methods of judging the effectiveness of speech therapy are needed. The goal is doubly worthwhile since, if the stutterer's speech can be improved, most of the associated psychosocial and vocational problems which his stuttering creates will also be eliminated.

The State vocational rehabilitation agencies find that a major problem is the lack of guidelines that enable staff to relate speech impairment to occupational handicap. Moreover, standards of casework performance and progress in therapy are not so closely defined nor apparent in speech rehabilitation as in other areas. The resources that serve the hard of hearing can be effective for the Administration's drive for more hearing and speech centers relates to speech rehabilitation, too. Additionally, special emphasis is being given (1) to the development of authoritative literature on the handicapping aspects of speech disorders and their treatment and (2) to the fostering of voluntary work for the speech impaired throughout the national community on a level equal to that for the hearing impaired. The development of casework standards as guidelines for vocational rehabilitation counselors serving speech impaired clients has high priority.

Numbers Served by State Vocational Rehabilitation Agencies

The aim of the public vocational rehabilitation program is the preparation of the occupationally handicapped disabled person for suitable employment. The State vocational rehabilitation agencies actually determine eligibility and provide services using grant-in-aid funds administered by the Rehabilitation Services Administration.

All of the resources of the public vocational rehabilitation services are directed toward the occupational adjustment of the person whose disability is a vocational handicap. The media for attaining this end with each client are the case services that are patterned to individuals needs. The research, training, and facility development activities of the Rehabilitation Services Administration and the State agencies are carried on for the purpose of strengthening case service techniques, developing new ones, improving the capacities of the case worker and the personnel upon whom he draws, and developing resources for better diagnostic, evaluation, training and restoration services. The dual aim of sharp increases in the quality and quantity of services and persons served permeates the whole program.

The extent to which the State agencies rehabilitated the deaf, the hard of hearing, and the speech impaired in the fiscal year 1974 and the numbers estimated to be rehabilitated in fiscal years 1975 through 1977 are shown in the following table:

NUMBER OF REHABILITANTS OF THE STATE VOCATIONAL REHABILITATION AGENCIES WITH SPEECH AND HEARING IMPAIRMENTS, FISCAL YEARS 1974 - 1977

	Estimated and actual number of rehabilitants in fiscal year			
	1974	1975	1976	1977
All rehabilitants	361,138	324,039	335,400	361,700
Number of rehabilitants with major disability of speech or hearing..................	21,300	18,500	19,100	19,400
Deaf......................	7,600	6,500	6,700	7,100
Hard of Hearing..........	10,500	9,400	9,700	9,500
Speech....................	3,200	2,600	2,700	2,800

The effectiveness of casework rests in appreciable measure upon the joint planning of the counselor and the client. Clients who are hard of hearing or who have serious speech problems of other than hearing origin tax even the most skilled caseworker. Even so, counselor and client do have a line of verbal communication which encourages rapport. They can develop a good rehabilitation plan together. The profoundly deaf client, however, especially that large majority who have serious language deficiencies, are not able to communicate by normal means. This is the crux. There must be communication between counselor and client for effective casework.

The State agencies have recognized this basic factor and are moving to rectify it as qualified workers become available or through special training of current counselors. Fifty States 1/now have or are actively recruiting staff who may be classified as expert vocational rehabilitation workers for the deaf since they are trained as professional counselors and are also able to communicate by sign language with deaf clients. Several of the States are searching for and others have already secured additional qualified counselors because their caseloads of deaf clients have rapidly grown beyond the capacities of the special staff as their deaf citizens have become aware that the vocational rehabilitation agency is now able to work more effectively with them. Forty-eight States now have coordinators, too, to oversee and develop their vocational rehabilitation programs for the deaf and hearing impaired. The Rehabilitation Services Administration urges, that each State have at least two highly skilled vocational rehabilitation counselors for the deaf and preferably that there be one in each metropolitan area.

1/ Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

A continuing problem in the area of the hard of hearing through the years has been developing and maintaining adequate channels of referral of hard of hearing persons needing vocational rehabilitation services. Major efforts have focused on encouraging the professional, the medical, and the voluntary worker to refer persons with hearing impairment to State vocational rehabilitation agencies for evaluation and consideration of possible services. The results have been disappointing as witnessed by the relatively small number of hard of hearing clients rehabilitated each year as compared to the many thousands needing or able to benefit from our services. The persistence of this problem has encouraged us to look to other channels by which more persons may become knowledgeable of their entitlements under the vocational rehabilitation service. Accordingly, we have now established formal working relationships with the National Hearing Aid Society, a principal feature of which encourages referrals by hearing aid dealers of persons coming to their attention who may be eligible for the services of our State agencies. If this move is as effective as we expect, the number of hard of hearing rehabilitants each year should increase rapidly into the tens of thousands.

Service Centers

Most of the many hearing and speech centers that have been established in the past twenty years have come into being in universities as training and research facilities, in large hospitals as service units, and in metropolitan areas. They fill vital rehabilitation needs in diagnosis, in evaluation, in training, in lipreading, speech, and listening, and in selection of hearing aids. We may have as many as 900 centers of widely varying levels of effectiveness and uneven geographic distribution. Many thousands of people with communication problems are just too far away from even the least of these service centers and even further from the more technical assistance that they may need. For example, a hard of hearing person who is 50 miles away from lipreading instruction, auditory training, hearing aid evaluation, is not likely to be able to travel this distance several times per week for instruction and service. The Rehabilitation Services Administration is attacking this problem directly through encouragement of projects that bring the basic hearing and speech services that the majority of these disabled people need into the local community at a cost that it can afford to maintain, leaving for the more comprehensive center the intricate services needed by more difficult hearing or speech cases.

In this respect the State vocational rehabilitation agencies are making important contributions to the availability of hearing and speech evaluation services through grants to extend and improve vocational rehabilitation services for the communicatively impaired. In 1969 alone, ten State divisions of vocational rehabilitation established facilities or special programs to improve services to the communicatively impaired. Authorizations under Sections 2, 3, and 4(a)(2)(A) were used in the creation of 25 projects at a total cost of over one-half million dollars.

The practical needs of deaf people are little related to speech and hearing centers. Almost all of them have had several years of intensive, expert training in speech and use of residual sound perception in their special schools. The deaf need the same vocational rehabilitation services as other clients, specifically diagnosis, evaluation, training, counseling, and placement, but in language that they understand. There are very few persons in rehabilitation centers or vocational schools who can communicate with deaf people to the point where a good learning situation may be said to exist. Consequently, the Rehabilitation Services Administration has had to concentrate on developing centers where there are expert professional workers for the deaf. Usually, these have proven to be the residential schools for the deaf. Diagnostic, evaluation, prevocational, and adjustment centers have been established or are planned at the State schools for the deaf in twenty-seven 1/ States.

Encouraging by-products of this activity are taking place in other States and there are growing efforts by established rehabilitation centers to qualify themselves to serve the deaf. Community service centers for deaf people, relieving residential schools for the deaf of counseling responsibility of deaf adults, are located in ten metropolitan areas and being planned in others.

Justification

The provision of specialized comprehensive rehabilitation services for a significant number of deaf people whose maximum vocational potential has not been reached continues to be a challenging and unmet need. These deaf people who have been estimated to number as many as 100,000 are severely limited in personal, social and vocational adjustment. Appropriate resources for them are just now beginning to be developed.

Rubella (German measles) epidemics in the 1960's have resulted in large numbers of deaf children having multiple disabilities. These rubella children have been swamping our schools for the deaf and will soon begin to present a new and demanding challenge to rehabilitation agencies.

Deaf persons whose maximum vocational potential has not been reached, who have not had the advantage of special training, have several characteristics which create difficulties for them in entering and holding gainful employment commensurate with their potentials. Some of these characteristics also account for their inability to qualify for existing post-secondary training programs for the deaf. Their problems cluster around vocational rehabilitation, educational and social underachievement, severely limited skills in communication and adjustment to requirements of daily living and, in some, the presence of secondary physical disabilities.

The majority of these severely handicapped persons have normal strength, intelligence and mobility. Recent research in providing vocational and adjustment training to deaf persons with serious personal, social and work adjustment problems has demonstrated that given proper assistance all of them can improve substantially in their ability to live independently and function more normally in their families and communities. This assistance needs to be provided on an intensive, long-term basis by staff who are able to communicate with them, possess a full understanding of their handicaps, and are skilled in the use of instructional techniques and tools for overcoming these handicaps.

The authorization in the Rehabilitation Act of 1973 for special projects and demonstrations to provide vocational rehabilitation service which hold promise of expanding or otherwise improving rehabilitation services to handicapped individuals (especially those with the most severe handicaps) including deaf individuals presents means for long-needed project development for severely handicapped deaf people. The projects will at long last make it possible to provide them with the special type of services they need to become employable or better employed.

1/ Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Maine, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Vermont, and Wisconsin.

Of long concern to the Rehabilitation Services Administration has been the void in vocational training for deaf clients. The accelerating inroads of automation seem to have sharply reduced the number of entry level jobs by which the deaf have gained their footholds in industry. Consequently, more vocational training has been necessary for deaf people who frequently are poorly served or not at all by overcrowded vocational schools. This has intensified the training void for deaf people that exists between the special school system which generally terminates at 9th grade or less and Gallaudet College, a void which has nurtured and partially perpetuated their serious underemployment. Fortunately, the situation is changing for the better as programs are being developed to meet the various service needs of the deaf adult population.

Accomplishments

The establishment of the National Technical Institute for the Deaf authorized by Public Law 89-36 in 1968 was a very important step toward reducing the underemployment of deaf people. It is contributing vital new concepts in the training of deaf people and through its special job development and placement program opening employment that has not had many or even any deaf practitioners. The State vocational rehabilitation agencies are directly involved with every student.

Great strides are being made in vocational training for deaf people at existing community facilities. Demonstration programs at Delgado College, at Seattle Community College and at St. Paul Technical-Vocational Institute successfully integrated deaf students using support services such as interpreting, notetaking, tutoring and counseling. New and better employment opportunities opened to deaf people as they completed their training. The programs did much to stimulate interest at other schools in providing vocational training to deaf individuals. Currently, approximately fifty community colleges are sponsoring vocational training programs for deaf people modeled on the success of the three demonstration programs. The programs serve as vitally needed training resources for deaf clients of State vocational rehabilitation agencies.

A small but important beginning was made in 1974 in providing services to deaf people who have not achieved their maximum vocational potential. Three special projects funded by RSA were established in Indiana, Washington State and South Carolina to provide comprehensive rehabilitation services to severely handicapped deaf people for whom no programs previously existed. One additional project was set up in 1975 in California. and three more will be developed by 1977.

The Communicative Skills Program, a long-term training project funded by RSA now in its eighth year, continues its work to increase the number of rehabilitation personnel, professionals in allied fields and employers and co-workers of deaf people able to communicate with deaf persons in their sign language. Over sixty universities now offer credit courses in manual communication as a by product of the greater awareness and interest generated by the Communicative Skills Program.

The Registry of Interpreters for the Deaf, a former RSA project, is expanding and accelerating its certification program to meet the critical need of State vocational rehabilitation agencies for an adequate supply of certified interpreters to work with counselors serving deaf people.

The National Interpreter Training Consortium, a long-term training grant program funded in fiscal year 1974 by RSA involving six regional training programs, is expediting the development of certified interpreters needed by State vocational rehabilitation agencies. By 1979, it is expected that each State will have interpreter training programs easing our present acute shortage of qualified interpreters.

DEAFNESS Annual, a document reporting on research and training activities and trends in the area of deafness with a directory of programs and services for the deaf, is an indispensable tool to the State vocational rehabilitation agencies and to professionals serving deaf persons. The Professional Rehabilitation Workers with the Adult Deaf, which prepares and publishes the annual report, began this work as a RSA project.

Sixteen States 1/ have developed or are currently developing mental health programs for deaf people. The State of New York which absorbed the pioneering RSA supported demonstration mental health project for the deaf at the New York Psychiatric Institute provides the background for the developing programs. It is anticipated that additional States will commence this much needed work as more mental health workers who are able to communicate with deaf people become available.

1/ California, Connecticut, District of Columbia, Florida, Indiana, Illinois, Minnesota, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Texas, Utah, Washington, Wisconsin.

Rehabilitation Services Administration Training Grants in Speech and Hearing (Speech Pathology and Audiology and Rehabilitation of the Deaf)

Rehabilitation Training

		1975 Actual	1976 Estimated	1977 Estimated
SPA and Deaf	Total	$2,671,717	$2,805,000	$2,500,000

Accomplishments

Training grants are available under the rehabilitation training program to support training in the areas of speech pathology and audiology and rehabilitation of the deaf. Since support of rehabilitation training was initiated in 1958, the number of training institutions has grown gradually and commitment of these institutions to train professionals in this specialty has been significant.

The focus in the Rehabilitation Act of 1973 on serving the severely disabled will impose new demands on the current available manpower providing services to a significant number of communicatively handicapped individuals in this country. Manpower will be needed to serve the deaf and the severely hearing impaired, the stroke patient with aphasia, and the laryngectomee population.

Special attention is being given under the rehabilitation training program to increasing the supply of qualified interpreters for the deaf.

Requirements in FY 1977

Training support in FY 1977 will continue to emphasize the training of skilled interpreters for the deaf to be available to assist State vocational rehabilitation agencies in providing services to severely disabled deaf individuals. Effort will also be made to improve the manual communication competence of students enrolled in training programs in established rehabilitation disciplines such as rehabilitation counseling and speech pathology and audiology.

REHABILITATION RESEARCH AND DEMONSTRATIONS

Hearing and Speech

Recent review and analysis of available data indicate that the actual prevalence of speech, hearing, and language disorders in the United States is double previous estimates. Approximately 20,000,000 persons have communicative handicaps, with at least one-third of these suffering either substantial or severe social, education, and economic disadvantage. This relatively large portion of the handicapped population present a continued challenge to rehabilitation. Most communicative handicaps have their origin in childhood from varied causes, such as birth defects or injury, cultural deprivation, untreated disease, etc., but persist into adulthood. However, other causes occur in later life, such as problems of aphasia-related stroke, accidents, or brain injury, and problems of traumatic hearing loss due to excessive exposure to noise. Continued emphasis must be placed on the development of test instruments to assess the communicative behavior problems in order to facilitate rehabilitative and therapeutic goals.

Computer assisted instruction and programmed materials are being developed for clinical rehabilitation use of speech and hearing handicapped persons. The breakdown of communication barriers will allow for increased work potential and thus increased earnings for such individuals. There must be continued development of clinical procedures to assist aphasic patients, laryngectomies, and stutterers in social adjustment as the individual returns to his family and to the work community. Projects concerned with the rehabilitation of the hard-of-hearing, especially in culturally deprived populations and with the older American, will be encouraged. Greater emphasis must be placed on developing the full vocational potential of persons with varying degrees of speech, hearing, and language disorders.

Deaf

Problem areas for members of the deaf community have been found to include (1) basic language disorders underlying the communication handicap; (2) social and cultural deprivation; and (3) lack of awareness of the vocational opportunities which do exist. Our goals include the stimulation of projects concerned with basic rehabilitative procedures in language, with community efforts on behalf of the deaf, and with the expansion of vocational opportunities.

Vocational and technical education opportunities, for deaf persons at the post-secondary education level have been incorporated into regular service programs. There are projects in operation concerned with the development of mechanical aids to assist the teaching of language to the deaf. Several projects have begun which deal with the integration of deaf persons into the hearing community; projects concerned with providing mental health services; and projects involved in opening new job opportunities for the under-employed deaf. Data from a national census of the deaf are being utilized in program planning. A major thrust will be projects focusing on social interactivities of the deaf in hearing settings. Continued emphasis will be placed on the assessment of the potential of multi-purpose rehabilitation settings to serve the deaf community. An important area of focus will be on provision of improved services to severely disadvantaged deaf adults through facility demonstration including a free-standing residential facility. Development of telecommunications, including cable, and exploration of improved training techniques for deaf people are being thoroughly explored.

	1973	1974	1975	1976	1977
Rehabilitation Research and Demonstrations	$1,000,000	$ 250,000	$ 180,000	$ 180,000	$ 250,000

REHABILITATION RESEARCH AND TRAINING CENTERS

Hearing and Speech

The New York University Deafness Rehabilitation Research and Training Center provides a continuing framework for research and training in the problems of communication as related to the disabilities associated with the totally deaf; conducts research and training in the evaluation and diagnosis, treatment, counseling, training, and placement of individuals with a wide range of speech and hearing disabilities in addition to their major rehabilitation specialties.

In Fiscal Year 1975, the New York University Deafness Research and Training Center and six other Research and Training Centers conducted a total of 27 speech and hearing related research projects in such areas as technological sensory aids for the deaf, speech therapy in aphasia, social interaction among aphasic individuals, evaluation of speech intelligibility of stroke patients, and input and output measures in aphasia.

In Fiscal Year 1975, the New York University Deafness Research and Training Center conducted 17 short and long-term training courses for 475 rehabilitation workers from all the disciplines involved in the rehabilitation of the deaf. Examples of such training include courses in Principles, Techniques and Problems of Psychological Counseling with Deaf Persons, Disturbances of Communication, Community Service Programs for Deaf Persons, Communicating with Deaf Persons, Psychology of Deafness, etc. In addition, most of the Research and Training Centers in Medical Rehabilitation offer both short and long-term courses in Speech Pathology, Audiology, Communication Disorders, etc. All the 19 Research and Training Centers have established close working relationships with the Regional Offices as well as with the State Vocational Rehabilitation Agencies, and they have addressed their needs in research and training as these pertain to the deaf population.

	1973	1974	1975	1976	1977
Research and Training Centers	$ 400,000	$ 480,000	$ 500,000	$ 500,000	$ 500,000

HEARING AND SPEECH

Obligations Fiscal Year 1973 to Fiscal Year 1977

Agency and Program	1973 5.9%	1974 5.9%	1975 5.7%	1976 5.7%	1977 5.5%
OFFICE OF HUMAN DEVELOPMENT					
Rehabilitation Services Administration:					
Basic State Grants..	$34,751,000	$38,350,000	$38,760,000	$38,760,000	$39,600,000
Service projects....	280,000	140,000	581,000	435,000	1,229,500
Rehabilitation training..........	3,767,067	270,800	2,671,717	2,805,000	2,500,000
Rehabilitation Research and demonstrations.........	1,000,000	250,000	180,000	180,000	250,000
Rehabilitation Research and training centers..	400,000	480,000	500,000	500,000	500,000
Special foreign currency program..	400,000	-	350,000	200,000	200,000
Total, RSA.......	$40,598,067	$39,490,800	$43,042,717	$42,880,000	$44,279,500

HEARING AND SPEECH

Obligations Fiscal Year 1973 to Fiscal Year 1977

Agency and Program	1973	1974	1975	1976	1977
OFFICE OF EDUCATION:					
Elementary and secondary education.........	$19,800,000	$15,200,000	$11,000,000	$11,600,000[1]	$11,700,000
Education for the handicapped..........	32,795,771	44,034,537	55,306,000	53,818,000	53,818,000
Occupational, vocational, and adult education.	4,883,200	3,800,000	3,800,000	1,000,000[4]	1,000,000
Library resources.	50,000	40,000	40,000	30,000	30,000
Research and training........	2/	---	---	---	---
National Advisory Committee on the Handicapped[3]...	26,081	32,484	100,000	100,000	100,000
Subtotal, Office of Education....	57,555,052	63,107,021	70,246,000	66,548,000	66,648,000

1/ The programs in these activities which supplied funds for hearing and speech are being consolidated, in fiscal year 1976, into a consolidated education grants program which specifies that 50% of the funds included in the consolidation must be used for the same purposes for which they were used previously. Beginning in 1977, total grant consolidation will be achieved.

NOTE: Of the activities reported from the Elementary and secondary education appropriation, Title I is not in the consolidation; Title IV is.

2/ Program transferred to the National Institute of Education in fiscal year 1973.

3/ From 1972-1973, amounts are for the National Advisory Committee on Education of the Deaf; during 1974, this Committee combined functions with the National Advisory Committee on Handicapped Children to form a new National Advisory Committee on the Handicapped. This activity was previously reported under the Office of the Secretary.

4/ New legislation will be proposed for most of the programs involved. No estimates can be included for those activities.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of Education

Programs for the Speech and Hearing Impaired

According to the most recent estimates of the American Speech and Hearing Association, speech and hearing disorders account for about 21.0 million handicapped individuals. Of this number approximately 3.0 million possess learning difficulties severe enough to interfere with communication and the development of normal speech and language. Six hundred thirteen thousand are totally deaf, and thereby incapable of understanding speech through the auditory mechanism. About 5 million represent children and adults with significant speech and language difficulties generally unrelated or only in part related to learning disorders. Among the types of speech and language problems found are those related to stuttering, aphasia, articulation and voice disorders, and developmental language disorders. These problems may be related to other handicaps such as cerebral palsy, mental retardation, learning disabilities, larynxectomy, and emotional disturbance.

The Office of Education has expanded significantly its activities related to improving and enlarging educational opportunities for hearing, speech, and language handicapped children in the past several years. In fiscal year 1975, 49,340 children with speech and/or hearing handicaps were provided with services at the preschool, elementary, and secondary school levels. In the same year, 23,380 children with hearing problems were served in State-operated or State-supported schools.

Elementary and Secondary Education

Title I

The purpose of the P.L. 89-313 Amendment to Title I, Section 121, P.L. 93-380, is to provide assistance to the States for the education of handicapped children in State-operated and State supported schools. A new provision beginning in fiscal year 1975, requires that if a child is transferred from a State-operated or supported program to one operated or supported by a local school system that the P.L. 89-313 funds follow him there.

During recent years, as local facilities for the handicapped have increased, State schools have found the composition of their resident populations changing from the midly handicapped to large percentages of children who are severely and/or multi-handicapped. Model and pilot programs for these types of children have been conducted under P.L. 89-313 in many States.

During fiscal year 1973 about $76,000,000 was appropriated to serve handicapped children in this program. Of this amount about $11,000,000 was expended for children with hearing problems. During fiscal year 1974, 22,166 children with hearing defects were served through expenditures of about $11,400,000. In fiscal year 1975 we served 22,700 children with about $11,000,000 and in fiscal year 1976, with about $11,600,000 we served the 22,900 hearing impaired children. For fiscal year 1977 we would estimate serving 23,000 hearing impaired children at an expenditure level of approximately $11,700,000.

Title IV

Title IV of the Elementary and Secondary Education Act (P.L. 93-380) provides non-matching grants to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs. At least fifteen percent legislation (excluding Title V funds) are to be devoted to programs for education of handicapped children.

A majority of the special education projects funded under this program involve some type of speech and hearing component.

Education for the Handicapped

The Bureau of Education for the Handicapped (BEH) is administratively organized into four major divisions under the Office of the Deputy Commissioner. Each of the major divisions -- Personnel Preparation, Assistance to States, Media Services, and Innovation and Development -- functions as an integral element in the total BEH program for handicapped children. The following pages describe the functioning of each division as it relates specifically to the speech and hearing impaired.

Division of Assistance to States

Under this division, there are two branches. One administers the Aid to States program, and the second runs the severely handicapped programs. which includes the Deaf-Blind Program.

Aid to States Branch

A. Branch purpose.

The Aid to States Branch is responsible for administering and monitoring programs of assistance and also providing technical and developmental assistance to States in the design, development, implementation and review of State plans for the education of the handicapped. The Branch also serves as a clearinghouse of information concerning novel and/or effective approaches to special education in other States.

B. Historical Development.

The purpose of Title VI, Part B, Education of the Handicapped Amendments of 1974, P.L. 93-380, is to provide funds for the States for the initiation, expansion and improvement of special education and related services for handicapped children at the preschool, elementary, and secondary school levels; and may be used for the early identification and assessment of handicapping conditions in children under three years of age. Beginning in fiscal year 1975, the State plan must include a goal of providing full educational opportunities to all handicapped children and provide a procedure to assure the accomplishment of this goal, with priority expenditure of funds going to serve children who are not receiving an education. The State plan must also provide for procedural safeguards concerning the identification, evaluation and educational placement of the children.

With the passage of P.L. 94-142, "The Education for All Handicapped Children Act, the focus of this program changes from being primarily a catalytic or technical assistance effort to one of stringent implementation. The new law mandates that the Federal government administer all of these programs under the requirement that the States set in motion plans and procedures to provide a free appropriate education to all handicapped children by 1978. The responsibilities of the Federal government to enforce this law require that the compliance of the States and local agencies must be monitored to determine that the States adapt extensive placement and individual child planning procedures in support of their timetable to provide a free appropriate education for every handicapped child.

C. Impact on Speech and Hearing.

During fiscal year 1973, about $37,500,000 was obligated for the Part B program. Of this amount $8,000,000 was expended on behalf of speech and hearing handicapped children. In fiscal year 1974, a total of 49,340 children with speech and/or hearing handicaps were served with $8,800,000 of a total Part B appropriation of $47,500,000. Of the $100,000,000 appropriated for each of the fiscal years 1975 and 1976 $14,300,000 will provide hearing and speech services for 80,000 children in each year.

Special Services Branch - Programs for the Severely Handicapped

A. Purpose.

The Special Services Branch, of the Division of Assistance to States, monitors two special programs directing attention to severely handicapped children and youth. "Telecommunications for Severely Handicapped Children and Youth who are Homebound," was designed to explore the effectiveness of modern telecommunications technology in the provision of educational training services to those severely handicapped children and youth who are homebound due to restricted mobility or to other aspects of social performance of physical involvement. "Programs for Severely Handicapped Children and Youth" provides for the funding of projects which would provide in conjunction with relevant public and private agencies and organizations within a State: (a) a plan for comprehensive services designed to meet identified, developmental needs of severely handicapped children and youth; (b) a model, demonstration program providing direct educational and/or training services for those children and youth which can ultimately be replicated State-wide and throughout the nation; and (c) a dissemination strategy whereby information about exemplary program activities or elements will be made widely known to both professional and nonprofessional personnel working with or interested in the education/training of severely handicapped children and youth.

B. Assessment Needs.

It is estimated that nearly one million severely handicapped children and youth are totally excluded from the educational system of our nation. At least 300,000 others are not receiving adequate services.

The principal problems delimiting the delivery of effective educational/training services to severely handicapped children and youth, in those areas where such services are mandated or supported, include: (1) extensive deficiencies in personnel with expertise and experience; (2) lack of adequate, functional facilities; (3) general void of appropriate curricula, methodologies, and education/education/training programs; (4) scarcity of specialized materials and equipment; (5) limited child and youth identification; diagnostic, prescriptive, and placement services; and (6) a general apathy or lack of concern for the needs of such persons, as well as the near nonexistence of advocate groups organized and functioning on their behalf.

The extreme shortage of adequate facilities, staff, and programs, has in many instances limited placement options for severely handicapped children and youth to already overpopulated institutions where with a lack of funds, facilities, and staff, it has been impossible to provide little more than custodial care. Under more fortunate circumstances there may be more appropriate programs as institutions, and a variety of education/training service capabilities in home communities through mental health clinics, group homes, halfway houses, and interim care placement centers. The States of Washington and New York are among those implementing some of these techniques. The "Rosenberg Report," a study in New York State in 1969, found that almost one-third of the retarded children and adults institutionalized by the State could be placed in the community if there were appropriate mental health and day-school facilities for them. At the present time, adequate facilities for such placements are very limited.

Among the most isolated of all severely handicapped children are those who reside in the nations's "training schools for the retarded and mental hospitals for the emotionally disturbed." Many of these institutions are located far away from the developed community; often those in larger cities are in relatively isolated or inconvenient locations. Children in these institutions rarely leave the grounds of the facility and are almost never given the opportunity to participate in the educational programs of the local school district.

C. Current Activities.

The special Services Branch funded for continuation ten (10) programs and five (5) telecommunication activities for severely handicapped in fiscal year 1975. Seven new programs totaling $795,573, were funded, each directing attention to specific areas of the severely handicapped such as auditorial, visual, and orthopedic impairment, severely emotional disturbance and severely/profoundly retarded. The seventeen programs, totaling $2,826.00, will serve as model demonstration programs to be replicated throughout the States. The five telecommunication efforts totaling $1,328,779, deal with Telecommunications for Severely Handicapped Children and Youth Who are Homebound. Telecommunications can be a link between severely handicapped children and the improvement of their social skills and enrichment of their general life situation.

Historical Overview and Future Goals

Through activities addressed to the needs of the severely handicapped, we will undertake cooperative planning with related Federal agencies and with State departments.of special education to target resources at this population. There will be a program of technical assistance to State education agencies to improve both their management and planning techniques so as to make maximum use of all Federal resources that can be dedicated to the needs of the severely handicapped.

Since 1969, the Bureau has held planning workshops aimed generally at developing States' capacity to plan and prioritize for themselves. In the Spring of 1971, OE/BEH objectives for handicapped children were established to dramatize learning needs of severely handicapped children.

The specific strategy proposed for implementation by BEH during fiscal year 1976 as a sustained thrust toward meeting the educational/training needs of severely handicapped children and youth is: To develop and refine a national compact between the Office of Education and selected States on the education and training for the severely handicapped. The objective of this year's activity is to engage in a dialog with these States to determine the feasibility and possible deficiencies of the task required to launch the implementation stage of such a national plan. In furtherance of the intent of this year's activity, it is visualized that we would pursue this effort along two lines: (a) technical assistance to the several States to explore various areas of mutual concern, and (b) the development of benchmark data to be used in a preliminary assessment of the scope and quality of the plan.

E. Impact on the Speech and Hearing Impaired.

The following statistical analysis denotes the current participants in "Programs and Telecommunications for Severely Handicapped Children and Youth." As it reflects in the data presented, 4,319 were considered to be multi-handicapped. This category included children with speech and hearing deficiencies. In terms of money expended, the percent reflects approximately $1,468,276 on behalf of the multi-handicapped, which includes speech and hearing impairments.

Centers and Services for Deaf-Blind Children

A. Program purpose.

The purpose of this program is to "provide through a limited number of model centers for deaf-blind children, a program designed to develop and bring to bear upon such children, beginning as early as feasible in life, those specialized, intensive professional and allied services, methods, and aids that are found to be most effective to enable them to achieve their full potential for communication with and adjustment to, the world around them, for useful and meaningful participation in society and for self fulfillment.

These centers will develop and provide services to children who are deaf-blind and have been deprived of their major avenues of learning and contact with the every-day experiences of life.

B. Historical Background, Legislation and Funding.

Public Law 90-247 was passed in response to the rubella epidemic (German measles) that swept the nation and left many children with auditory and visual impairments, as well as other handicapping conditions including mental retardation. Approximately 5,064 children were left deaf and blind. There were no programs in existence for such children at that time. In 1969, the first eight regional deaf-blind centers were started. In 1975, we have a total of 9 deaf-blind centers and one single State center serving deaf-blind children in all 50 States and U.S. Territories.

Total funding approved for Centers and Services for Deaf-Blind Children, by school year, is as follows:

1969-70	$ 1,000,000
1970-71	2,000,000
1971-72	4,500,000
1972-73	7,500,000
1973-74	10,000,000
1974-75	14,055,000
1975-76	12,000,000
1976-77	16,000,000

4,516 deaf-blind children are in various types of educational programs located in public and private institutions and State hospitals for the mentally retarded. Some of the types of services offered by the Deaf-Blind Program are as follows:

1. Full and part-time education services (both residential and day)
2. Diagnosis and Evaluation
3. Parent Counseling
4. In-Service Training
5. Short term programs (summer school, respite care)
6. Pre-vocational programs

C. Impact on Speech and Hearing

By definition, all of these children have speech and hearing problems. Therefore, 100% of our children being served have speech and hearing problems and are receiving appropriate services in this area.

Division of Media Services

Under the Division of Media Services, there are three major activities: the Media services and captioned films, Recruitment and information, and Regional resource centers. Of these three programs, only the media services and captioned films program directly impacts, in a definable way, on the hearing and speech-impaired. While efforts in the other two programs are not targeted on any individual handicapping condition, they do have an impact on these people.

Media Services and Captioned Films

A. Program Purpose

This program, authorized under Part F of the Education of the Handicapped Act provides the handicapped learner with specific educational materials directed at educational needs. This purpose is being advanced through the operation of Centers for Educational Media and Materials for the Handicapped and a network of Area Learning Resource Centers which focus on the development and dissemination of materials and media for the education of the handicapped. Another major purpose is the captioning and distributing of motion picture films and other media to the deaf and hearing impaired population.

B. Historical Development

During 1974 and 1975, more than 4,363 groups of hearing impaired persons, representing an audience of 3.0 million people, were reached through the Media Services and Captioned Film program. Of these, 1,541 were schools or classes for the deaf. The total audience for theatrical films numbered over 1.6 million with a monthly average of 4,000 showings.

The program circulated more than 700 different captioned educational films through its 60 film depositories.

In 1976, the number of groups of hearing impaired persons reached will exceed 4,800 (1,600 schools and classes for the deaf). The captioned theatrical and cultural films will reach a total audience of 108 million persons with a monthly average of 4,000 showings.

Support of the National Theatre for the Deaf is continuing, and a daily captioned evening news broadcast over the national PBS network was continued. Experiments to develop and electronic coding system to provide captioned television programming to a potential audience of more than 13 million hearing impaired Americans are now in the testing stage and a national system is expected to be operational in 2 years.

The National Center on Educational Media and Materials for the Handicapped is conducting a needs assessment of specific requirements and standards for media and materials for handicapped children. The network of 13 Area Learning Resource Centers and 4 special category centers is providing a national delivery system of educational media to handicapped children.

C. Impact on Speech and Hearing Handicapped

The speech and hearing handicapped population of this country has been and continues to be one of the principal beneficiaries of this program. Over 3,900 groups of hearing impaired persons participate in the media services and captioned films program. Captioned theatrical and cultural films reach over 1.3 million persons. The captioned newscast on PBS television is a daily occurrence and the support of the National Theatre of the Deaf allows it to play a major role in the cultural, educational, and vocational betterment of the deaf. Obligations in the program are as follows:

1973	$12,767,000
1974	13,106,000
1975	13,000,000
1976	17,262,000
1977	16,000,000

Division of Personnel Development

Special education manpower development for fiscal year 1975, approximately 5,200,000 was obligated for awards for speech and hearing. We anticipate the same amount will be obligated in fiscal year 1976, 1977, and 1978. The Division of Personnel Preparation has moved completely to Program Assistance Grants. While our expectations are that the number of trainees directly supported will rise slightly, we do not delineate all trainees according to distinct handicaps.

In addition, the State Educational agencies expended approximately $800,000 mainly through special study institutes and summer session traineeships in order to upgrade and update the skills and knowledge of inservice speech and hearing personnel.

Although the school-age population of deaf children has remained relatively constant in the past few years, the downward extension of educational services to very young preschoolers has increased the total number. It is estimated that there are over 50,000 deaf pupils in the United States. Due to a shortage of teachers and other obstacles, an additional 14 percent are not receiving the specialized help necessary from schools and classes appropriately equipped to serve these children.

Division of Innovation and Development

A. Early childhood education

Part C of the Education of the Handicapped Act enables the Commissioner of Education to make grants or contracts to public and private non-profit agencies for the development and implementation of model and demonstration programs. These grants are distributed on a broad geographical basis throughout the nation.

The goal of this program is to demonstrate a variety of approaches for providing services to young handicapped children and their families. The projects are intended to serve as models for agencies wishing to replicate project or its components.

Parent/family participation is an important part of each project's activities. Assessment of child progress, inservice training, coordination with the public school and other agencies, and evaluation are other components.

After the three-year period of Federal support for demonstration those projects which have obtained funding from State, local or other sources to continue the basic service component become eligible to apply for funding to carry out outreach activities designed to enable other agencies to provide services for young children with handicaps. Many of the projects are involved in providing training or resource assistance to Head Start projects which wish to enroll children who have handicaps.

The Act provides for a Federal share of up to 90 percent of the cost of a project. During 1972-73, the entire early education program, which serves all types of young handicapped children, including 71 local activities and was funded at 7 million dollars. In fiscal year 1973, total obligations for the program were $13,325,000; in fiscal 1974, $16,151,000 in fiscal year 1975. $14,000,000, and fiscal year 1976, an estimated $22,000,000. Of the total program the portion estimated to be devoted to hearing, speech, and language development is about 20%; in fiscal year 1973,

B. Research and demonstration

a. Purpose

This program promotes and supports research and related activities which show promise of leading to improvement in educational programs for handicapped children. Support is available for research, dissemination, demonstration, curriculum, development and media activities.

b. History

This program, administered by the Research Projects Branch, was initiated during fiscal year 1964 with an appropriation of one million dollars authorized under Title II, section 302 of P.L. 88-164. Through the ensuing years, the authorization has been continued, and the scope and flexibility of the program have been expanded. In April 1970, the various acts of legislation that pertained to research were incorporated into P.L. 91-230, Education of the Handicapped Act. The latest act, P.L. 93-380, provided for authorizations of appropriations through fiscal year 1977.

The following table provides data on the number of projects and amount of support specifically related to the education of speech and hearing impaired children.

Division of Innovation & Development
Projects Research Branch
Projects on Speech and Hearing

Year	Number	Amount
1964	9	$ 184,691
1965	12	307,032
1966	31	$1,019,470
1967	38	1,710,970
1968	34	2,205,722
1959	34	1,608,517
1970	21	1,876,327
1971	19	1,825,406
1972	11	1,742,489
1973	12	1,602,637
1974	18	828,771
1975	13	1,076,426
1976	20	850,000

In addition to these projects, an increasing proportion of research funds have been allocated to projects which impact more generally on the education of the handicapped children. In general, such "non-categorical" projects have tended to equal or exceed the amount of activity directed specifically at the field of speech and hearing, and may be assumed to have virtually as much an impact on programming in the field as do those projects which relate to problems specific to the speech and hearing impaired.

C. Impact on Speech and Hearing Disabilities

It is often difficult to assess the direct impact of research activities on educational programming since the lag between the discovery of new knowledge and consequent changes in educational practices obscures the relationship. However, a number of suggestions regarding program impact are available. As of the end of fiscal year 1974, supported projects had resulted in the distribution of over 500 projects reports relating to education of the handicapped through the ERIC system, and at least an equal number of publications in referred professional journals. In addition, validated curriculum materials designed specifically for the speech and hearing impaired have been developed and are now available in the areas of articulation therapy, language for the deaf, and control of stuttering. Special education instructional materials center and regional resource centers for the handicapped which began as development/demonstration projects supported through the research program have now become institutionalized service operations providing services to the speech and hearing impaired as well as other handicapped populations.

D. Current Activities

Current project efforts supported by the Research Projects Branch are involved primarily with the development and validation of more effective and efficient methods for correcting disabilities in the area of articulation, particularly program instruction and automated systems, delivery systems for speech and hearing services, and language development of deaf children.

E. Future Goals

A substantial portion of the activities currently supported by the Research Projects Branch are designed to further specify future plans and programs in the support of educational research relating to the handicapped. The initial stages of this planning effort suggest strongly that efforts in the area of speech will continue to be addressed primarily to improvement in delivery systems for speech therapy services in the public schools and that efforts relating to the hearing impaired may focus strongly on language and speech development activities. However, it would be premature to suggest specific goals in view of the heavy current investment in projects which are designed to lead towards planning decisions.

Vocational Education

At least ten percent of the basic grant funds under the Vocational Education Amendments of 1968 are mandated to be spent on the handicapped. This category includes those who are hard of hearing, deaf, or speech impaired. From the descriptive reports of the States which are submitted annually, there are a number of programs in which these particular handicapped students are being served.

Illustrations of the kinds of programs carried on in some States are: pre-employment vocational experience programs; vocational printing; office occupational aptitides; utilization of teacher and instructional aides to provide individualized instructions; work adjustment.

Vocational Education reporting system does not collect data for each category of the handicapped.

However, enrollments of all handicapped students in vocational education programs reached 234,115 in fiscal year 1974. Estimates for 1975, 1976, and 1977 are 266,000, 290,000, and 310,000 respectively. Of the total allocation provided under the Vocational Education Act, (VEA) in fiscal year 1974, the States collectively used $42.305.000 for programs serving handicapped students. In 1975, 1976, and 1977 it is expected that the States will continue this level of support using from $42,500,000 to $43,000,000 of their Federal allocation to serve handicapped students.

Adult Education

Adults with speech or hearing impairments who have not attained the equivalent of a high school education are eligible to attend adult education programs. It is estimated that approximately 2% of the total effort in State grant funds are used for educational programs designed specifically for under-educated adults with such impairments. In fiscal years 1975 through 1977 it is estimated the same level of support will continue.

It is anticipated that continued emphasis will be placed on staff development needs of supervisors, teachers and para-professionals working with adults who have hearing impairments. The fact that the Education Amendments of 1974 consolidated the national teacher training and special project resources into the State Grant will enable the State agencies to earmark more resources for the handicapped.

Library Resources

Through fiscal year 1971, funds under Title IV-A of the Library Services Construction Act were for the purpose of establishing and improving State-supported institutional library services. Residential schools for the Handicapped, including hard of hearing, deaf, and speech impaired may be included in a State plan if these schools are operated or substantially supported by the State. Funds may be used for providing books and other library materials as well as other library services to students in such residential schools under an approved State.

National Advisory Committee on the Handicapped

The National Advisory Committee on the Handicapped is composed of special educatiors, persons interested in education and welfare of the handicapped, and regular educators. The Advisory Committee is required by law to carry out the following functions: (1) make recommendations to the Secretary for the development of a system for gathering information on a periodic basis in order to facilitate the assessment of progress and identification of problems in special education; (2) identify emerging needs respecting special education and suggest innovations which give promise of meeting such needs and of otherwise improving the educational prospects of handicapped individuals; and (3) suggest promising areas of inquiry to give direction to the research efforts of the Federal Government in improving the education of the handicapped. In fiscal year 1974 the National Advisory Committee on Education of the Deaf and the National Advisory Committee on Handicapped Children combined functions to form the new National Advisory Committee on the Handicapped.

The obligations for fiscal years 1972-1976 are as follows:

	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate	1977 Estimate
Salaries and Expenses	$26,081[1/]	$32,484	$100,000	$100,000	$100,000

1/ For the National Advisory Committee on the Education of the Deaf.

HEALTH SERVICES ADMINISTRATION
BUREAU OF COMMUNITY HEALTH SERVICE
Hearing, Speech and Language Disorders 1/

	Actual Obligations 2/			Estimated Obligations 2/	
	1973	1974	1975	1976	1977
Special Projects......................	930,000	700,000	800,000	900,000	900,000
Children and Youth Projects...........	745,000	760,000	2/	2/	2/
University-Affiliated MR Centers......	1,000,000	1,100,000	1,100,000	1,170,000	1,170,000
Subtotal......	2,675,000	2,560,000	1,900,000	2,070,000	2,070,000
Research					
Direct Impact.......................	303,500	186,000	186,000	170,000	170,000
Indirect Impact.....................	895,000	624,000	624,000	600,000	600,000
Special Foreign Currency Program......	97,000	100,000	100,000	50,000	50,000
Total	3,970,000	3,370,000	2,810,000	2,890,000	2,890,000

1/ Report represents the activities under Title V, Social Security Act (Maternal and Child Health Service Programs).

2/ Excludes formula grant funds expended by States for hearing and speech activities, for which reports are not submitted.

HEALTH SERVICE ADMINISTRATION

Bureau of Community Health Services

Hearing, Speech and Language Disorders Program

(Title V, Social Security Act, Maternal and Child Health)

The Bureau of Community Health Services, Health Services Administration, administers funds appropriated under Title V of the Social Security Act for Maternal and Child Health and Crippled Children's Services. These funds are available as formula grants to State Maternal and Child Health and Crippled Children's agencies, to meet the requirements of Title V including the requirements for projects for the comprehensive health care of children and youth, maternity and infant care, dental health care, training of professional personnel and for research related to the health of mothers and children.

The Bureau of Community Health Services assists state and community health agencies in planning, developing and evaluating programs of health services for children including those with communicative disorders of speech, hearing and language. These efforts consist of (1) providing technical assistance by staff which is consonant with the national goals and objectives of the HSA and BCHS (2) initiating, conducting and supporting efforts by grants and contracts to improve speech and hearing services and the related delivery system (3) issuing program guidelines and other material relevant to the needs of professionals and parents (4) reviewing the performance of programs and initiating studies which focus on improving the quality of services, the extension of services, and the training of personnel, as related to the development and disorders of speech, hearing and language.

The data in the table accompanying this report represent the obligations and expenditures for speech and hearing services which have been included in the different categories of project grants. The amounts expended by the States for speech and hearing services under the Title V formula grants have not been reported by the States thus, the total national cost of the program for speech and hearing is not identified.

The Problem

Of the 83.8 million children under 21 years of age in the United States in 1970, there were 9 million who were handicapped according to estimates prepared by the Rand Corporation for the Secretary of the Department of Health, Education and Welfare (R-1420-HEW, May 1974, p.3). Among these there are 2.7 million with hearing and speech impairments. These estimates of the prevalence clearly indicate that communication disorders are of a magnitude that a significant effort is required in the prevention, detection and treatment of the problems. There are almost a half million children and youth who are hard of hearing or profoundly deaf.

Studies have shown that if the hearing loss exists from birth or early years, the child must receive early rehabilitation and training if the handicap in communication is to be prevented or effectively managed. The fact is that for many children the treatment programs have often been delayed until the school years. Recent legislation in many states to require educational services for handicapped children at preschool ages is a compelling reason for health agencies to increase their efforts to find and diagnose children whose handicaps may include communication disorders.

The etiologies of hearing impairment can be roughly divided into two categories which are susceptible to preventive actions, early detection and early and comprehensive treatment. One category includes those conditions related to maternal health, the course of the pregnancy, the delivery and aftercare. This category requires the provision of comprehensive health services for the mother and newborn. It includes the provision of the Rh anti-immune vaccine and the rubella vaccine as well as other efforts to prevent diseases which affect the sensorineural system. The other category includes those hearing problems related to malformations, disease and dysfunctions of the upper respiratory system and the middle ear. This category requires that the detection of the hearing problem be accomplished as early as possible to avoid further medical complications as well as the effects of deprivation of auditory stimuli. Accurate diagnoses must be made promptly so that treatment will be appropriate and of a quality most likely to help the child.

Speech and language problems are caused also by conditions other than hearing impairment, and are frequently the reason parents seek health services. A wide range of problems may so seriously interfere with the child's communicative skills that he is handicapped educationally, socially and vocationally. While treatment and training is often directed solely at the child's speech and language impairments, there has been increasing attempts to integrate the efforts of multiple disciplines. To meet this need for team oriented clinicians further development of interdisciplinary training programs and further refinement of standards of quality of care are required.

The problem of increasing the effectiveness of care while at the same time reducing its cost requires that one of the program objectives must be to improve the continuity of services. The treatment program for communicative disorders requires coordination between the health service specialists and the school clinicians, and between clinical services and the home. For such continuity to be established and improved, there must be an improved coordination among the programs for speech pathology and audiology services at all levels of the government. Such requirements have led to the formulation of the following general goals.

Goals

The BCHS program for speech and hearing services under Title V, Social Security Act, is guided by the following goals:

1. To assist State and community health agencies to develop additional programs and to extend present programs, especially to infancy and early childhood, for the prevention, identification, diagnosis and treatment of communicative disorders of hearing, speech and language.

2. To increase the availability of manpower and to improve the quality of the personnel and facilities available to serve children with hearing, speech and language disorders.

3. To identify problems related to providing or improving specialized services and to develop and support studies pertaining to these problems in serving children with communicative handicaps.

State Agency Programs

The services provided in a hearing and speech program in a State Maternal and Child Health or Crippled Children's Service program include medical and surgical treatment, hospitalization and aftercare, audiology and speech pathology services, nursing, social work and psychology services and other health services as required, including the provision of hearing aids. While services for hearing and speech impairments are provided in each of the States, the nature and scope of these services vary among the States and among communities within the States.

Some of the activities related to a hearing and speech program are basic activities related to overall preventive health services and general health care provided to children. For example, the program for immunization is significant in the prevention of disease leading to sensorineural hearing impairments. Similarly, medical treatment of upper respiratory infections, and acute otitis media is a significant part of preventing conductive hearing impairments. The health services required for an effective hearing, speech and language program include a wide range of disciplines involved in casefinding, assessment, medical and non-medical treatment and therapy, counselling and habilitation.

In all but nine states, either the Maternal and Child Health agency or the Crippled Children's Service agency, or both, employ professionally qualified speech pathologists or audiologists to be responsible for the development and implementation of a program for hearing and speech services. Speech and hearing programs in State Maternal and Child Health and Crippled Children's Services Agencies provide services both directly and indirectly in a variety of different delivery systems.

Casefinding, preventive and diagnostic services, in many states are provided directly by State personnel at both the professional and supportive personnel levels. Treatment services for both hearing and speech impairments in some States are provided by state employed staff, but most often are purchased from existing hearing and speech facilities and from professional personnel in hospitals, rehabilitation centers and other facilities. Speech services usually are provided as an integral part of the services for children with other handicapping conditions, including mental retardation, cerebral palsy and cleft palate. For fiscal 1973, the hearing of more than six million children was tested. The number of children who are found by these hearing tests to need medical and other help is, on a national average, approximately 2% to 3% of the total. This national average, however, fails to emphasize the fact that in some geographic areas the prevalence of significant hearing impairment is 15% and in Alaska, for instance, it is above 30%. The number of persons who are profoundly deaf from birth is approximately two per thousand in the general population. In fiscal 1973, the total number of children with cerebral palsy served by the Crippled Children's Service was more than 40,000 and those with cleft lip and palate were more than 23,000. The Crippled Children's Service reported providing services to more than 64,496 children with hearing impairments; of these more than 23,000 were served for the first time in fiscal 1973.

Bureau of Community Health Services Program

Technical assistance by professionally qualified specialists is provided to State health departments and crippled children's services and to other grantees receiving funds under Title V, Social Security Act, as well as to appropriate voluntary and professional organizations. Financial assistance is provided through grants and contracts for special projects in the area of speech and hearing which are of regional or national significance.

Hearing and speech services are an integral part of Title V project grants for comprehensive health services for children and youth who live in poverty areas. The projects provide screening, diagnostic, preventive, corrective and followup services for children of families who live in low income areas. About 75 hearing and speech specialists have been employed as staff in these projects to provide speech pathology and audiology services.

Special projects specifically concerned with hearing and speech services include grants to the Colorado Department of Health for demonstrations related to communicative disorders; the Iowa State Services for Crippled Children to explore developments in providing hearing and speech services to mentally retarded children; the Alaska State Department of Health and Social Services to develop a joint program of audiology services with the Alaska Native Health Service.

Special training projects in speech pathology and audiology continue to receive grant support at the Howard University, John Hopkins University, University of Iowa, University of Oklahoma Medical School, the New York University Medical School, and Vanderbilt University Medical School. The project at Vanderbilt University includes a cooperative training program with Tennessee State University, a historically black institution. This project, and the project at Howard University are developing new patterns of professional preparation for speech pathologists and audiologists to serve children whose cultural and linguistic backgrounds are different from that of the specialist.

In addition, training for speech pathologists and audiologists is included as one of the more than fifteen health professions which receive support for training in twenty University Affiliated Training Centers. The purpose of this training is to increase the effectiveness and quality of interdisciplinary and multidisciplinary care to handicapped children.

Grant support has been continued for research studies related to the service needs of programs supported by Title V funds. A study recently completed at the University of Hartford, is concerned with developing automated procedures for evaluating of the language functions in infants and young children with severe auditory impairments. The Langley Porter Neuropsychiatric Institute is conducting a study to describe the development of parent-child communication in families with a child who is deaf. A study of the auditory and visual perceptual deficits related to neonatal jaundice is being carried out at the Pennsylvania Hospital in Philadelphia. The New York University study of the behavior of school age rubella children has yielded important insights with respect to their hearing impairment. A number of research projects supported under Title V, Social Security Act, are not specifically aimed at speech and hearing disorders but nevertheless are expected to have an impact of the delivery of speech and hearing health services.

Continuing activities in research under the International program include studies of the methods for the early detection of hearing loss. Such studies have been supported with special currency funds in Israel, Poland and are being continued in Yugoslavia. A project in Egypt has as its purpose the development of a hospital-based model for delivering speech and hearing services.

Planning

One of the sub-objectives of the speech and hearing program has been to aid the profession to function effectively in whatever health delivery system is finally evolved. National conferences of leaders in public health, of directors of speech and hearing clinical services, of directors of training in speech pathology and audiology have been held to implement this objective. Additional meetings will be held in 1976 with the assistance of the BCHS staff. These meetings will include a national conference of speech pathologists and audiologists to consider issues related to the assessment and assurance of the quality of services in health oriented speech and hearing centers.

The effort to encourage speech pathologists and audiologists to become knowledgeable in comprehensive planning for health service will be continued. The end result expected is a decrease in the likelihood of fragmentation and overlapping of services and the inefficient use of community resources.

A long term objective of improving the evaluation of the effectiveness of speech and hearing services is being continued. This effort has refined operational definitions and developed a coding system for data collection and analysis related to the projects for health services to children and youth.

Developing an evaluation system for training programs has been the focus of a grant made to the University of North Carolina. This effort to assess and critically evaluate the procedures used in the University Affiliated Centers will be continued.

The speech and hearing program is actively promoting the development of criteria and standards for speech and hearing services which will contribute to the Professional Standards Review Organization (PSRO) program while at the same time implementing the mandate of Title V (Social Security Act) to conduct quality improvement efforts.

The Early Periodic Screening Diagnosis and Treatment program (EPSDT) under Title XIX (Social Security Act) mandates that services for hearing impairment be provided. In many states these services are provided by the State maternal and child health or crippled children's programs in accordance with agreements with the Title XIX agencies. In most States there is a need to develop agreements or to refine existing agreements. Professional consultation will be provided at the federal level and to State programs to achieve efficient use of the resources available consistent with standards of the Title V programs.

HEARING, SPEECH, AND LANGUAGE

The Communicative Disorders Program of the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) is concerned with research to improve the diagnosis, treatment, and prevention of diseases and disorders affecting the ear, nose and throat and problems relating to hearing, language, and speech. Under the recent reorganization of the Institute a Communicative Disorders Program area has been established for all Institute-supported research in these fields. The Institute's name also has been changed to reflect its long-standing commitment to the communicative sciences.

The NINCDS program in communicative disorders presently includes 204 research grants, 16 program projects and clinical research centers, 14 contracts, and 49 training grants, including institutional research service awards to universities and medical centers.

The Communicative Disorders Program is expanding its directed research into new problem areas, particularly those which do not receive funding from other Federal agencies. These include improved objective identification of young hearing-impaired children; better measurement, treatment and prevention of speech and language disorders among adults who have experienced stroke or head trauma; effects of noise on children; noise and speech communication; and improved assessment and treatment of language disorders not apparently attributable to sensory impairments. The Program is supporting research on wearable master hearing aids and on the extent to which deaf persons are able to integrate electronic analysis of speech as cues.

The NINCDS Laboratory of Neuro-Otolaryngology in Bethesda, Maryland, is providing leadership in revealing some of the inner ear functions which were previously not understood. Chief among these is the process of transduction, whereby sound waves (mechanical energy) entering the ear are converted into nerve impulses (electrical signals) for transmission to the brain for processing, utilization, and storage. The Laboratory is studying biochemical mechanisms of the inner ear which are intimately related to the transduction process. Understanding these mechanisms should be an important step toward developing rational methods of dealing with the most prevalent type of hearing loss and the type which has not been amenable to treatment, i.e., sensori-neural hearing loss (due to loss of the nerve function of the ear).

Research on noise is a collaborative effort between the NINCDS and the National Institute of Environmental and Health Sciences (NIEHS). Such research is concerned primarily with the biological effects on the sense organs, and is attempting to identify various environmental factors such as chemicals, drugs, and other agents which contribute to hearing loss. Also under investigation are specific endocrine, immunologic, pharmacologic, teratogenic, cardiovascular, and other mechanisms which may be affected by chronic noise exposure.

The National Institute of Child Health and Human Development (NICHD) promotes understanding of developmental processes in persons of all ages. Research deals with normal acquisition and development of speech and language skills, including reading, and with problems of communication related to mental retardation and other developmental disabilities. This Institute also has a strong interest in the prevention of the variety of factors which may lead to hearing, speech or language disorders.

Moreover, reading and other language-related learning disabilities affect a large segment of our Nation's children who are otherwise of normal intelligence. These children are also one of deep concern to the NICHD.

In addition, the NICHD currently supports 183 research grants, training programs, individual fellowships and research contracts related to hearing, speech and language. The NICHD also supports 12 Mental Retardation Research Centers which conduct investigations in language acquisition, and in the development and training of the mentally retarded child. Among the handicaps shared by the mentally retarded, language deficiencies are probably the most common.

The National Institute of Dental Research (NIDR) supports research on cleft palate (an incomplete closure of the roof of the mouth) and other oral-facial defects. NIDR has awarded 9 research grants, including several to research treatment teams, 4 training grants and 1 fellowship for study of this anomaly which occurs once in approximately every 600 births.

HEARING, SPEECH, AND LANGUAGE

Obligations Fiscal Year 1973 to Fiscal Year 1977

Agency and Program	1973	1974	1975	1976 estimate	1977 estimate
National Institutes of Health:					
National Institute of Neurological and Communicative Disorders and Stroke..........	$10,240,000	$12,164,000	$14,539,000	$16,644,000	$16,249,000
National Institute of Child Health and Human Development.....	11,752,000	1[illegible],612,000	15,453,000	15,401,000	14,373,000
National Institute of Dental Research........	1,774,053	2,385,227	1,694,281	1,699,816	1,700,000
National Institute of Environmental Health Sciences.	212,000	460,000	510,000	360,000	515,000

NATIONAL INSTITUTES OF HEATLH

National Institute of Neurological and Communicative Disorders and Stroke
National Institute of Child Health and Human Development
National Institute of Dental Research
National Institute of Environmental Health Sciences

HEARING

The Problem

Impairment of hearing is the most prevalent chronic disability in the United States. The most recent census of the deaf in the United States shows that there are currently 203 deaf persons for every 100,000 in this country--more than twice the number counted in the last census. In all, there are between 13 and 14 million people in this country with sufficient hearing loss to affect significantly their ability to function effectively in everyday activities. In addition, an earlier national survey has indicated that the incidence of ear disease, which could lead to hearing loss if untreated, is far more prevalent than was previously thought.

The ultimate goals of hearing research are the prevention and cure of hearing disorders, but many basic questions regarding the nature of the hearing mechanism need to be answered before these goals are met. The answers should come, however, with an increasingly precise understanding of the anatomic, physiologic, and biochemical processes. Much of the NINCDS research is directed toward understanding these basic functions, but support is also given to clinical studies on improved treatment for afflicted persons.

Hearing and Normal Communication

Persons with hearing handicaps are known to have difficulty learning to speak, yet many of the underlying relationships between hearing and the acquisition of verbal communication are not known. In order to elucidate the effect of hearing impairment on speech and language development and the impact of speech and language problems on the mentally retarded, the NICHD has developed a major contract at its University of Washington Mental Retardation Research Center on the language acquisition of normal, hearing impaired, and Down's Syndrome children. This project is primarily concerned with children under three years of age. One of the major advances of the project is in the area of assessing the hearing (audiometry) of infants under one year of age. This involved the use of both impedance audiometry, which requires no active participation by the infant and behavioral audiometry in which the infant is trained to respond every time he hears auditory test signals. Impedance audiometry provides information about specific parts of the auditory system, primarily the middle ear. Behavioral audiometry provides information about the auditory system as a whole, and about the functional relation between the infant and his auditory environment. To date the team has been able to obtain significant auditory threshold data from infants as young as five months of age. Recently the behavioral approach used to obtain thresholds from infants has been extended to obtain suprathreshold measures of the speech discrimination abilities of infants as young as six to eight months old. The assessment of auditory abilities during the first year of life has major significance for early treatment programs.

Other investigators have based their behavioral audiometry procedures for infants on the work of NICHD grantees at the University of Kansas Mental Retardation Research Center where operant audiometry was developed to test profoundly retarded individuals. The researchers at Kansas have extended their use of basic operant audiometry in threshold testing to teach even severely retarded children to make auditory discriminations. Once a child is systematically trained to respond, by being brought under stimulus-response control, a variety of tests can be administered. Such a training program can be a basic key to training in other forms of communication.

Identification of Hearing Disorders

Four unique procedures to identify hearing problems in the very young, are presently being evaluated by NINCDS supported researchers. Early identification of children with hearing impairments has long been a concern shared by physicians, hearing and speech specialists, and educators. If the problem can be treated medically, more permanent damage to the hearing mechanism may be averted and the child is able to undergo speech and language development more normally. If treatment is not possible, the child may be fitted with a hearing aid and education of both the child and the parents can be started at the beginning of the child's language learning years.

The lack of a reliable test to screen newborns has forced physicians to rely on a high-risk registry to identify infants with a high probability of deafness, based on family history.

Several recent developments indicate that reliable tests may soon be available that will permit large scale screening for all newborns.

Crib-o-gram. NINCDS-supported scientists at Stanford University School of Medicine have developed a new automated test to detect hearing impairments in newborns. The crib-o-gram system detects continuous lack of response to auditory stimuli and works on the principle that babies in a relatively quiet condition will respond to loud sound by startle or other movement, whereas babies in an active state will often respond by becoming quiet.

The device detects infant movement in the crib and records any test changes when a test sound is turned on. It can be used on a large series of babies; results are tabulated by computer. Extensive trials are now being conducted at a number of hospitals across the country.

Impedance Audiometry. NINCDS-supported researchers at Baylor University are continuing to evaluate a new objective test which may be applied to very young children.

The test is based on findings that measure eardrum movement in response to different types of noise and can be used to predict hearing threshold levels. On the basis of these findings the scientists have evaluated a large series of patients in an attempt to predict sensori-neural hearing loss.

The new test, which proved highly accurate, holds great promise as a predictive test of hearing loss in children. The procedure can be done with a child of virtually any age with a minimum of difficulty. A manual on how to use this and other procedures on very young children has been prepared by the NINCDS and will soon be available for distribution.

Electrocochleography. At the University of Chicago, NINCDS-supported researchers have developed a research technique for obtaining an objective test of hearing function which may be useful in small children and hearing impaired adults. Called electrocochleography, it picks up electrical impulses which are produced in the cochlea (the organ of hearing in the inner ear) and monitors the excitations believed to be produced by different stimulating frequencies. Results are computerized and emerge as patterns. NINCDS-supported investigators at other institutions are currently conducting studies to validate the procedure.

A further development of this principal has been worked out by NINCDS-supported scientists at the Eaton-Peabody Laboratory of the Massachusetts Eye and Ear Infirmary in Boston. In an attempt to determine the functional state of the auditory nerve fibers, researchers are recording auditory nerve signals from the ear canal following acoustic stimulation with tones of successive frequencies. It is hoped that this painless, non-invasive technique can be used as an office procedure to diagnose otologic problems.

Brain Stem Audiometry. NINCDS grantees at the University of California at San Diego and other research centers have shown enthusiasm for brain stem audiometry in which computer-summarized brain waves are analyzed to determine functioning of the auditory system. By means of earphones, the infant is presented with a series of clicking sounds that stimulate the auditory nervous system. The electrical activity evoked by the sounds in the brain is picked up by electrodes, fed into a computer and printed out in the form of waves on a graph. Proponents of this approach believe they are able to detect in the averaged computer output the neural activity which occurs at each progressively higher level of the central auditory system.

Evaluations of this approach are in progress and if successful, it could have extensive clinical use. Procedures such as this undoubtedly will help to assess more accurately persons unable to participate in voluntary hearing tests such as young children, the mentally retarded, and accident victims.

Congenital Hearing Problems

A primary target for prevention is hereditary deafness, which accounts for approximately 40 percent of deafness at birth. More than 40 types have been identified, most of them resulting from defects in five or six genes. NINCDS grantees at Johns Hopkins University have described two of these disorder complexes—one involving recessive microtia or abnormally small ears with hearing loss, and the second characterized by recessive achalasia or tense gastrointestinal muscles, piebaldism or absence of pigment in skin and hair, and hearing loss. Better understanding of the genetic nature of various hereditary disorders undoubtedly will aid in counseling prospective parents.

One way to study hearing disorders is to grow the organ of hearing in tissue culture. Two NINCDS supported research groups in Wisconsin and New York have removed from mice the fetal precursors of the hearing organ and have been able to grow the organ with its auditory nerve in culture. With this technique they can study the sensory cells in normal animals and in animals with genetic defects of the organ of hearing and/or the auditory nerve. These pioneering studies of mammalian hearing are vitally important. Not only is there a wide body of genetic knowledge on the mouse, but an animal model such as this may be used as a model for hearing disorders in humans. Already data about certain embryological mechanisms elucidated in these studies have been used as a basis for important clinical considerations in the management of congenitally deaf children.

Approximately 10 percent of deafness present at birth results from prenatal rubella infection. The NINCDS Collaborative Perinatal Study of more than 50,000 women and their offspring, which was in progress during the rubella pandemic of 1964, showed that about one-half of the infants whose mothers had rubella during the first three months of pregnancy are deaf. Of these, approximately one-half also have impaired function of vestibular structures (part of the inner ear concerned with balance). Fortunately, rubella vaccine, which was developed after the 1964 pandemic, has helped reduce the incidence of maternal rubella and consequently is reducing the incidence of hearing loss in infants.

This is an example of what can be accomplished through prevention and can be applied to other viral infections which are implicated in congenital deafness.

Infections

A significant cause of hearing loss is otitis media, an inflammation of the middle ear, which commonly develops from infection in the nose and nasopharynx. It can cause up to a 35 to 40 decibel hearing loss if left untreated, but usually responds to treatment with antimicrobial agents. (A decibel is a unit used for measurement of the level of hearing sensitivity.)

Serous (or secretory) otitis media results from fluid collecting in the middle ear, either following acute infection or after prolonged blockage of the eustachian tube (the pressure-equalizing connection between middle ear and nasopharynx). Serous otitis media, usually unaccompanied by pain, causes hearing loss often undetected for considerable periods. It has been estimated that probably over 50 percent of children have at least once such episode during their first 2 years of life.

Although effective treatment can usually be achieved with antibiotics and decongestants, plus myringotomy (surgical opening of the eardrum and removal of the accumulated fluid) when indicated, serous otitis media frequently recurs. Since one explanation for recurrence of serous otitis media is eustachian tube malformation, one aspect of current research is centering on the mechanisms of eustachian tube function and management of tubal disease.

NINCDS grantees at the University of Minnesota have succeeded in developing an animal model for serous otitis media. Data from these studies will be used by scientists at the National Institute of Allergy and Infectious Diseases to develop and evaluate vaccines against this disorder.

The Minnesota investigators also reported recently that, contrary to earlier beliefs, in successfully managed cases of early otitis media there is a residual hearing loss. These findings emphasize the need to protect these children from factors potentially harmful to hearing since damage to the hearing mechanism is cumulative.

Otosclerosis

Thirty types of hereditary deafness are known in which the onset is delayed. The most common of these is otosclerosis, which is characterized by growth of abnormal spongy bone in the bony framework of the middle ear so that the stapes, which normally vibrates and conducts sounds to the inner ear, becomes fixed. Remarkable strides have been made in treating and restoring hearing in these patients with surgery. Researchers are presently evaluating agents which might prevent or even reverse the bony changes that block the hearing mechanism.

Tumors

Infection of the ear sometimes can produce a growth in the middle ear, cholesteatoma, resulting in loss of hearing. NINCDS grantees at the University of Iowa, studying the cause of cholesteatoma, have been able to induce this growth in an animal model (guinea pigs) to follow the progression of this disorder. The investigators hope to gain information that will lead to prevention and improved management of the problem. An International Conference on Cholesteatoma to be held in this country later this year will include in-depth considerations of the biology, epidemiology, cause and management of cholesteatoma.

Ototoxic Agents

Data from basic and clinical studies are enabling scientists to draw an increasingly precise picture of how noise affects the hearing mechanism and to define noise conditions injurious to hearing.

Certain drugs have been found over the past few years to cause hearing loss. These include antibiotics such as streptomycin, kanamycin, gentamycin, and neomycin plus ethacrynic acid (the major component of a medication used clinically). The toxic doses and site of injury have been defined for a number of these agents. To alert practicing physicians, and provide researchers with current information on drugs which are or may be toxic to hearing, the NINCDS supported the publication of the "Index-Handbook of Ototoxic Agents, 1966-71."

Noise

Exposure to noise of sufficient levels for long enough periods can produce temporary, chronic, or permanent hearing losses. Noise can interfere with speech communication and with sleep; it can be a source of annoyance and a stressing agent. Noise constitutes one of the leading threats to hearing. More than 16 million Americans may be exposed to dangerous noise levels on the job. Another 10 million urban dwellers are often exposed to harmful loud noise levels.

Much of the basic work in determining the relationship between levels and duration of noise and permanent hearing loss has been supported through the NINCDS. Grantees have produced evidence that there is no simple way to predict which individuals will be most susceptible to noise-induced hearing loss. These findings indicate a need for regulations to protect the hearing of the total population or the establishment of procedures to monitor individual hearing levels. Persons who develop slight noise-induced hearing loss can then be removed from the noise exposure to prevent more severe hearing loss.

NINCDS participates fully in the Interagency Panel on Noise Effects, sponsored by the Environmental Protection Agency. Members of this panel have reviewed all government-sponsored research pertaining to noise effects in order to identify important research gaps. NINCDS also participates in the Interagency Panel on Early Childhood Research and Development, sponsored by the Office of Child Development, and including a number of departments outside HEW and as well as agencies within HEW. NINCDS also coordinates its program with the National Institute of Environmental Health Sciences and the National Institute of Occupational Safety and Health.

Recently the Environmental Protection Agency issued noise-control regulations that eventually will ban the use of truck engines that are noisier than an automobile. The new rules, which also establish noise limits for portable air compressors, will be in force by the 1990's. Compressors and trucks covered by the new rules--the first products affected under the 1972 Noise Control Act--are two leading sources of excessive noise, particularly in urban areas.

A year ago, the directed research portion of the NINCDS noise program commissioned a literature review and analysis of effects of noise on children. This review, recently published, suggests that levels of noise which interfere minimally with the performance of adults on tests of speech perception may interfere substantially with children's understanding of speech, a conclusion that will be investigated further under NINCDS auspices. Furthermore, exposure to noise of sufficient levels for sufficient periods may affect the acquisition of speech and language, and listening skills.

Currently there is an emphasis on fitting hard-of-hearing children with hearing aids as soon as possible. It is not clear, however, whether hearing aids produce changes of hearing acuity in young children. The NINCDS recently awarded a contract to study young hearing-impaired children to determine whether hearing aids may contribute to further temporary or permanent hearing deficit in very young hearing aid wearers.

NINCDS-supported scientists at a number of research centers and universities are providing important information about the basic physiological structures and functions adversely affected by exposure to noise. Some of these studies are providing a correlation between noise dosage accumulated over a person's lifetime and impaired hearing.

Animal studies by NINCDS grantees at Washington University in St. Louis indicate that initial losses of hearing from noise can cause significant secondary losses. Hair cells (the sensory cells of hearing in the inner ear) destroyed by noise leave holes in the reticular lamina (a supporting surface of the hair cells) which eventually close with scar tissue. Once these holes are open and before scar tissue forms, however, fluid from other parts of the ear can leak into the organ of Corti (site of the hair cells) and damage other cells. The St. Louis investigators presently are measuring the time courses of the healing process in the hope of finding ways to accelerate healing and avoid secondary damage.

Studies have also been initiated by NIEHS scientists to explore the location and nature of physiological changes underlying the temporary threshold shift of hearing and the hearing recovery process. Measuring the electric potential produced by pure test tones following noise exposures at various sound pressure levels showed very evident hearing threshold shifts at the lower test tones and higher noise exposures with subsequent recovery. Prolonged noise exposure would have resulted in a permanent threshold shift in hearing. Evidence gained from temporary threshold shift data will be useful for predicting a permanent hearing loss over an extended pressure time. The next step will be to measure the temporary threshold shift caused by exposure to ototoxic antibiotics, alone and in combination with noise.

Acute noise exposure has been shown to affect markedly various hormone secretions. Immunological function can be affected by altered levels of certain hormones. Studies are being conducted by NIEHS scientists to detect alterations in cell-mediated immunity in noise-exposed rodents. Early data show some suppression of lymphocyte production following noise exposure.

Presbycusis

Often with increasing age there is variable sensori-neural hearing loss, even when no external direct causes of hearing loss are evident. This hearing loss accompanying the aging process and known as presbycusis remains one of the most prevalent, and as yet incurable hearing problems. The NINCDS has recently established a new laboratory of applied psycho-acoustics which will focus attention on the hearing problems of persons with acquired sensori-neural hearing loss.

Scientists have identified pathological changes in the temporal (ear) bone, including degeneration of certain inner ear structures. Evidence that disorders of the blood vessels may produce this degeneration also has been found.

Institute grantees recently conducted extensive studies using an experimental (non-wearable) master hearing aid to evaluate speech perception among presbycusic patients. This research, now published, is expected to spur additional study and to be applied by hearing aid manufacturers.

Also, NINCDS scientists have begun study of special auditory problems of persons with presbycusis. This research is focusing on effects of noise (levels as found in homes and offices) on discrimination of speech and speech-like patterns and is expected eventually to lead to improved designs for hearing aids.

Hearing Aids

For a very large portion of the deaf population neither medical nor surgical correction of their hearing loss is possible. Therefore, different types of aids for these people are of great help in their aural rehabilitation. NINCDS scientists have long been active in hearing aid research, to improve the quality of existing aids so that the hearing impaired can use their residual hearing more effectively.

The Institute has developed under contract, prototypes of two models of wearable master hearing aids which will enable scientists to determine methods for tailoring hearing aids of maximum efficiency for the individual wearer. One of these models is presently being evaluated by NINCDS-supported scientists at the Graduate Center of the City University of New York. The advantage of the wearable aid is that it can be tried in all types of everyday social situations which allows a more effective evaluation of the aid by a potential user.

In addition to on-going research specifically directed to hearing aids, NINCDS supports a number of other types of research expected to bring direct benefit to hearing-impaired persons. These include: research on tactile and visual aids for the deaf, research on psycho-acoustic processing by hearing-impaired persons, research on implanted auditory prostheses.

A piezoelectric transducer has been developed by NIEHS scientists which, when in direct contact with the ossicular chain (bones of the middle ear), can impart highly defined signals into the cochlea. Potentially this device may overcome some of the problems associated with the simplification of sound waves currently used in standard hearing aids.

Tactile and Visual Aids for the Deaf

One system under development, as part of an NINCDS-supported project at the Central Institute for the Deaf, extracts nasal vibrations, throat vibrations, and pressure near the speaker's lips and presents signals corresponding to these energy sources at three locations on the skin by vibrotactile means. Initial reports from this project indicate that significant, and sometimes dramatic improvements in intelligibility scores occur when the aid is combined with the lip reading technique.

In NINCDS supported studies at Johns Hopkins University, scientists are developing and evaluating cutaneous (skin) and visual-patterned stimulation aids to communication for the profoundly deaf infant. Tests are being conducted to determine the effectiveness of both visual-patterned stimulation and tactile-patterned stimulation on the development of vocalizations by these infants. It was found recently that even in this age group subjects can be trained to attend to both visual and tactile displays.

This past summer the NINCDS sponsored a workshop on tactile and visual aids for the deaf to review the state-of-the-art and identify pressing research needs. The workshop made a number of recommendations and particularly emphasized that the need for practical field trials with existing devices far outweighs the immediate need for developing new aids.

Prosthetic Devices

Possibly as many as 300,000 people in this country are profoundly deaf and must depend on lip reading and cues for communication. Scientists have long been intrigued by the possibility that if some residual auditory nerve fibers were present in these people, electrical stimulation of the fibers might produce auditory sensations. In recent years planned and directed efforts to study this phenomenon have been undertaken.

At the request of the Secretary of the Department of Health, Education, and Welfare, the NINCDS met with a representative group of researchers to discuss the current status of the feasibility of an implantable cochlear (auditory) prosthesis. As an outgrowth of that meeting, two workshops devoted to cochlear implants were held, one at Bethesda and one in San Francisco. Although recognizing the formidable obstacles in developing such devices, the conferees agreed that answers to the many problems in this area should be vigorously pursued.

A majority of the recommendations coming out of the workshops have been undertaken, including the development and miniaturization of suitable electrodes, the evaluation of long-term effects of stimulation on nerve tissue, and the objective evaluation of patients who have already received an implant device.

Research on auditory prosthetic devices for the deaf is in progress at a number of universities, medical centers and private organizations. Preliminary trials by NINCDS researchers with prosthetic devices that directly stimulate the auditory nerve (the primary nerve of hearing) indicate that pitch and amplitude may be grossly discriminated following intensive training, but complex tones and speech cannot be discriminated. Many scientists believe that the key to a successful implanted hearing device will come from discovering how the normal ear encodes auditory information and how this information is utilized by the central nervous system.

One investigator is studying the physiological responses in cats to stimulation by a multichannel electrode. The prevailing view is that encoding of intelligible speech, if ever possible, will require multichannel stimulation of a series of predetermined sections of the acoustic nerve. Scientists hope that if stimulation of a small number of predetermined sectors of the acoustic nerve can be accomplished, it may be sufficient for speech discrimination by subjects who are now profoundly deaf.

Advances in Basic Research

While efforts by NINCDS scientists to understand the physical aspects (anatomy and physiology) of audition have yielded real advances, how we hear remains a mystery. It is clear that the mechanical energy of sound waves must be converted into electrochemical messages before the brain can recognize sound, but the precise site and mechanism of this energy conversion, or transduction, is unknown.

Scientists have shown that the hundreds of microscopic hairs in the inner ear are the transducers for sound and that hair cells release transmitter substance which excites the auditory nerve.

In all probability the mechanical energy of hair cell movements is transduced or converted into electrochemical energy at the hair-bearing end of the cells. At NINCDS research is under way to uncover the mechanisms and exact site for the transduction and to identify the transmitter substance.

An important first step has been taken by NINCDS grantees at St. Louis in defining the chemical substances in the inner ear and the auditory portions of the brain that transfer information from one neuron (nerve cell) to another. NINCDS scientists using culturing techniques have worked out new methods for studying the biochemical mechanisms of the hearing organ. The new method is now being used in animal studies with very promising results.

Coordinated efforts by NINCDS supported scientists to study the auditory portions of the brain stem are expected to produce increasing information on how nerve cells are interrelated and how auditory information is transformed and encoded.

Institute scientists have worked out techniques for electron microscopic studies of the inner ear and have been able to produce remarkably detailed pictures of cell junctions in the hearing organ. This advanced technique has led to new findings which will be published in the near future. These investigators are also beginning to provide a detailed description of the intercommunications of those parts of the brain which process information on sound.

A more complete understanding of these basic mechanisms of inner ear function will provide the greatest step toward a rational basis of dealing with the many disorders of the ear which are still beyond medical control.

LANGUAGE AND SPEECH

The crucial nature of the communicative sciences and the disorders which impair normal communication can best be assessed by considering the close link between thought, speech, and language. Language depends upon the activity of the cerebral cortex, the last division of the central nervous system to develop. The language areas of the brain are located in close proximity to the thought association areas. Furthermore, the mastery of language proceeds hand-in-hand with the development of higher forms of anticipatory behavior.

Normal Language Development

Language is a formal system of rules for using signs and symbols as a means of communicating. It is usually accomplished through spoken or written words. Currently approximately 3.5 million children between ages 4 and 17 years have some degree of language disability.

The NICHD has supported several projects dealing with the acquisition of language. Because children everywhere learn spoken language as a matter of course, the complexity of the acquisition process and of language itself is frequently overlooked. The Institute, however, has encouraged scientists from many different disciplines to define the major unsolved problems and has stimulated research in how children develop language.

Through a contract developed with the Haskins Laboratories of New Haven, the NICHD continues to provide child development specialists and language scientists with natural and synthetic speech-like stimuli recorded in a precise manner and suitable for a variety of experiments. These recordings are prepared with highly specialized and costly equipment not available to most investigators. As a direct result of this NICHD contract, advances have already been made in speech and language perception which is leading to improved language and reading instruction, as well as better hearing aids for the hard-of-hearing.

Acquisition and Development of Reading

The NICHD supports research to determine how reading skills are acquired and overlaid upon spoken language in an effort to understand dyslexia, a specific language-related learning dysfunction reflected in reading problems. Such difficulties are found in children who ordinarily would be expected to be able to learn to read; that is, children of normal intelligence who are without sensory impairment, primary emotional problems, or obvious neurological damage and who have received adequate reading instruction. The information derived from this research will provide the knowledge base from which appropriate methods of prevention or treatment may be developed.

Language Disorders

Language development can be hindered or impaired from birth as a result of impaired hearing, mental retardation, infantile autism, or specific brain damage. Children who do not suffer from any of these problems but still fail to develop normal language skills often have what is termed a developmental language disability.

One language-impaired population which long has been neglected is autistic children. A research program on autism will be developed within the NINCDS based on recommendations coming out of the NINCDS-sponsored workshop to be held this year at the NIH campus. The goals of the workshop are to provide a working definition of autism, to assess the current status of neurobiological research on autism, and to identify promising research areas.

Scientists also are now assembling methods for examining the language development in all normal children of preschool age. The results will be used to assure parents that their child has learned each of the necessary skills in language before reaching school.

Efforts also are being focused on the early detection of preschool age children at a high risk of having a language disorder in order to reduce the impact of these disabilities on the development of social and cultural knowledge needed to function in society.

Directed research at NINCDS is focusing on the development of precise measures of children's language performance in neurologically impaired children. Recent studies of perceptual and cognitive abilities in children with dyslexia and verbal dyspraxia (impairment of needed coordinated movements for speaking) has helped to define the precise deficits of the children in each group and will serve as a foundation for developing language performance measures and improving treatment in neurologically impaired children.

To assure healthier children and adults the NICHD attempts through research to identify the causes of childhood morbidity so that developmental disabilities can be prevented. While recognizing the importance of early detection of high-risk infants, the NICHD focuses its effects on the prevention of those conditions which place children in such a category.

Researchers supported jointly by NINCDS and NICHD at the Parsons State Hospital and Training Center in Kansas, a special clinical and research center for mentally retarded children, are studying new strategies for training severely retarded children to learn skills which will enable them to learn language. The program includes training in auditory detection, speech sound discrimination, and categorization. The basis for symbolic communication is first taught through the use of small discs or forms upon which speech utterances are superimposed. These studies, which already have shown that children thought to be nonverbal can be trained to have some language skills, should provide some insight into the basic skills which neurologically impaired children must develop in order to learn language.

In another NICHD-supported project at the University of Kansas, an investigator made a significant bridge from basic animal work to the practical application of research to improving the quality of life of severely and profoundly retarded individuals. He has taken some of the basic principles derived from work with chimpanzees in the early 1970's and adapted them to the teaching of children. The first phases of this research demonstrated that many of the children with serious communication problems could learn, using "plastic words," to write sentences and to communicate with others. Subsequently, this approach to training was carefully studied to improve both effectiveness and efficiency. Additional training steps were prepared to help children with the greatest difficulties. Those parts of training which gave children the greatest problems were revised and tested until most children were able to progress through training with relative ease.

The procedures for teaching children to communicate with "plastic words" were later expanded to include procedures for teaching them to use speech. The outcome of this research has been a carefully designed set of step-by-step instructions which a teacher or parent can use to help a non-speaking child to communicate. The results from nearly 200 children indicate that over 95 percent are able to acquire some communication skills using these procedures. Many children have gone on to speech clinics where they have subsequently learned to carry on effective conversations.

This research has provided an approach that allows successful teaching of communication skills to many children for whom procedures were not previously available. It also suggests a variety of issues for future study that promise to further advance our knowledge about human communication.

Adult Language Disorders

Adults also develop language problems as a result of brain trauma, stroke, brain tumors, or infections. Usually the condition is diagnosed as aphasia, a severe language disorder that results in an inability either to assign meaning to words, to understand speech, and/or to organize words into thoughts. This devastating language disorder produces anxiety and confusion for persons who once had normal speech.

NINCDS-supported scientists at the University of Pittsburgh are studying how well aphasic adults are able to function independently in society, both prior to and following treatment. This new information will be a useful guide in the treatment and rehabilitation of these patients.

At Minneapolis Veteran's Hospital, NINCDS-supported researchers are developing a technique for describing the behavior of aphasic patients during therapy and identifying their difficulties in regaining language. This technique is providing new information for future development of improved treatment techniques.

NINCDS investigators at the Boston Veteran's Hospital have recently developed a substitute language system using visual symbols. Adult aphasic patients have been taught this new language system and use it to communicate effectively among themselves, hospital staff, and family members. Patients who have learned this substitute system are expected to regain some of their former language abilities more efficiently.

Speech Disorders

Speech disorders resulting from disturbances in muscular control of the speech mechanism caused by damage to the central and peripheral nervous system are known as dysarthrias. Many of these disorders are believed to arise from a disruption at the lowest level of nerve output. Disturbances within the nervous system can affect any or all aspects of speech production--respiration, phonation, articulation, and resonation.

One NINCDS grantee scientist at the University of Wisconsin is studying the coordination of muscular activity during speech production of dysarthric patients with neuromuscular impairments. The use of electromyography (to measure the electrical activity of the muscle fiber) to study lip movements during speech production has led to increased understanding of the bases for these patients' difficulties and the specific action of certain drugs on muscular function. As a consequence, more effective therapeutic techniques have been found to increase the accuracy of patients' sound production.

Patients with Parkinson's disease show a characteristic increased tension and rigidity of the muscles directly affecting speech. NINCDS-supported scientists have utilized bioelectric feedback to reduce lip tension in a patient with Parkinson's disease, thus removing undesirable lip retraction. Using lateral cineradiography (X-ray motion pictures), researchers have also been able to describe the nature of the disturbed tongue movements during swallowing and speech in patients with Parkinson's disease. Their results are defining the pattern and sequence of deterioration in vocal tract control in Parkinson's disease and can be applied to other progressive neurological diseases.

Articulation problems are the most common speech disorders, and seven out of every ten individuals with speech disorders have them.

NINCDS grantees at the University of Alabama have developed a computer-based system to correct speech articulation problems. The PAGIS system is used to measure the pattern of tongue contact against the roof of the mouth and the motions of the lips and jaws during speech production. The computer processes the information and plays it back to the clinician and/or the speaker. This feedback system may offer assistance to patients who are not helped through the traditional techniques of speech therapy.

Laryngeal Disorders and Cleft Palate

Speech disorders resulting from laryngectomy operations for cancer of the larynx are being investigated. Dramatic advances have been made in maintaining or restoring speech function following surgery for removal of the larynx (which contains the vocal cords). Improved methods of detection are enabling doctors to make an early diagnosis, before the damage is too widespread. In these cases, conservation surgery which removes only the cancerous parts of the larynx provides the best prognosis for the preservation of speech.

Several NINCDS grantees are gathering acoustic and physiological data on patients with voice disorders. Some of the work is directed towards finding methods of detecting early signs of laryngeal pathology and in particular laryngeal cancer. This is crucial since the outcome of treatment for this disorder is far more effective when an early diagnosis has been made.

NINCDS-supported scientists at several institutions are using computers to analyze voice patterns for clues to laryngeal pathology. Research at the University of Florida on speaker identification and recognition utilizing eye, ear, and computer technology represents a major contribution in the communicative sciences. Researchers have demonstrated that certain segments of the acoustical signal (voice print) are predictors of certain laryngeal pathologies. This noninvasive technique will permit early, accurate and painless diagnosis of certain laryngeal disorders. Animal and human hearing studies undertaken at the University of Florida compliment the speech investigation and are contributing to the development of a theory of speech production and reception.

NINCDS grantees in California are using a revolutionary new optical device to view the larynx and obtain new insight into laryngeal disorders. The investigators have used this system to record laryngeal disorders on still and motion pictures. The new device is simple, provides permanent documentation, and allows for repeated stopping for analysis of what in the past has been only a fleeting glimpse. Also, medical and speech therapy can be monitored with this device. It is hoped that specialists as well as general practitioners will be able to use the device for early detection of laryngeal lesions.

A head and neck registry is being kept at Washington University in St. Louis to maintain statistics on the long-term survival rates and quality of life of patients who have undergone larynx removal. For those whose cancer is too widespread for conservation surgery, speech prostheses are being developed by several investigators, while others are conducting animal studies to evaluate the possibility of reconstructing a normal larynx.

Bilaterally paralyzed vocal cords can be reactivated by use of a new surgical procedure developed by an investigator at State University of New York Upstate Medical Center at Syracuse. The procedure involves the borrowing of a donor nerve branch, intact in its muscle bed (an accessory respiratory muscle) and "plugging" it into the laryngeal muscle. The borrowed nerve is both readily accessible and fires spontaneously during inspiration. The procedure has been carried out successfully in eight patients, including one in whom the paralysis had been present for 51 years.

At the University of Iowa investigators supported by the National Institute of Dental Research are trying to solve some speech problems of children handicapped by cleft palate. In normal speech, most sounds require that the gap between the nose and the back of the throat be closed in order to force a stream of air out through the lips. Closing this gap demands coordination of muscles in the throat walls with those of the palate, and for many children with cleft palates this is difficult. If the palate is too short, it is impossible.

Speech specialists have devised a number of tests to predict whether a child with a repaired palate will be able to learn to speak normally or first must have additional surgery to help close the throat gap.

The Iowa scientists have evaluated three of these tests and report that all of them have about 90 percent reliability, but find that if they combine the information from two of them, their prediction rate improves to 96 percent. For good speech without further surgery a child must make high scores on both tests.

NIDR-supported scientists at the Cleft Palate Center of the University of Pittsburgh find that if they visualize in three dimensions how the throat gap is closed, they can also make good predictions about future speech capacity. X-ray pictures taken in three planes help to identify, record and determine the severity of closing irregularities. They have learned that certain closing patterns or shapes correlate with particular speech problems.

Some of these Pittsburgh investigators have also found that certain children who form abnormal throat closure patterns while talking can use the same closing mechanism normally for whistling and blowing. This ability suggested that perhaps the faulty speech of these children was not caused by an inability to coordinate muscles or by shortness of palate but by having learned to use the muscles the wrong way. The speech specialists have retrained a few of these children with a new type of operant conditioning. In a small preliminary study, the children with normal hearing soon learned to speak correctly, and the speech of one deaf youngster improved. However, the method is not applicable to children whose anatomy does not permit good throat closure.

NIDR scientists at Pittsburgh have been studying the hearing problems of children with cleft palate. Nearly all of these children during the first two years of life suffer from inflammation of the middle ear. The investigators find that the thick fluid which accumulates in the patients' ears is sterile, but causes loss of conductive hearing, and may contribute to neurosensory hearing problems if not relieved.

Although the eustachian tube in these children is seldom physically blocked, it rarely opens to permit drainage from the ear to the throat. The researchers believe the tube walls are too pliant to allow it to open normally during the process of swallowing. As a result, irritating secretions accumulate in the tube. Insertion of a plastic ventilation tube within the eustachian tube allows drainage; inflammation subsides and hearing improves. The research is showing that it is necessary to install the ventilation tube as early as possible, and to check the children frequently because these tubes can become blocked or slip out. Most children have fewer middle ear problems once their palates have been repaired.

Voice Prostheses

A new type of laryngeal voice prosthesis with no electronic components is undergoing development at the Northwestern University-McGraw Medical Center, Chicago, and affiliated hospitals. Unlike most other voice prostheses, the Northwestern model is designed particularly for those laryngectomy patients who have not yet learned or cannot learn esophageal speech. The artificial larynx can produce a very intelligible voice immediately.

At the University of Cincinnati and Washington University, St. Louis, NINCDS-supported researchers are working to reconstruct the larynx from natural tissue. Animal studies at Cincinnati, for instance, have shown that a functioning larynx in dogs can be made from their own throat tissues. Studies are now being conducted to see if this procedure can be applied to baboons, whose upright stance is similar to that of man. Construction of the new larynx has been completed, and investigators are now attempting to refine construction of the vocal cords.

The work of NINCDS-supported scientists has yielded important insight into the dynamics of respiratory functions specifically associated with speech and voice production. Since there is a positive correlation between variation in pulmonary expiratory pressures and loudness of sound during phonation, direct control of the expiratory muscles is of importance for the production of speech.

SHARING OUR RESEARCH FINDINGS

The dissemination of research findings and their application are considered by NIH to be one of its major functions. Each of the Institutes involved in communication research has held conferences and published proceedings.

The most recent conference proceedings in the NICHD's Communicating by Language series was published by The MIT Press in June 1975. The book, The Role of Speech in Language, examines such questions as: What is the relationship of speech to language? How does sign language differ from speech in shaping the intellect? What analogs to human speech development can be found in the patterned "verbalizations" of primates or in bird sounds?

Other publications in the Communicating by Language series are: Language by Ear an by Eye (The MIT Press), The Reading Process (GPO), The Genesis of Language (The MIT Press), and The Speech Process (ERIC). Pamphlets highlighting the most recent books in the series are available from the NICHD. They are entitled: "The Relationships Between Speech and Reading" and "On the Relationship of Speech to Language."

In co-sponsorship with its Mental Retardation Research Centers, the NICHD has also initiated a series of seminars which will result in state-of-the-art documents for the scientific community on aspects of mental retardation. Recognizing that language and communication are vital elements in the development and performance of the mentally retarded, and that communicative disorders are the most commonly shared handicaps of mental retardation, the first seminar in this series dealt with language and the mentally retarded. The proceedings resulted in the publication *Language of the Mentally Retarded*. To complement this effort, a second conference was held bringing together basic scientists and clinicians in the field of language. This resulted in the publication of *Language Perspectives--Acquisition, Retardation and Intervention*. This conference and publication bridges basic research and clinical application. Continuing the major emphasis on communication disorders, coupled with a concern for early detection, diagnosis, and treatment, a third conference on "Early Behavioral Assessment of Communicative and Cognitive Abilities of the Developmentally Disabled" is scheduled for May 1976.

The proceedings of many NINCDS-supported workshops have been published, including *Vascular Disorders and Hearing Defects*; *Sensory Input in Hearing Impaired Children*; *Cochlear Implants*; and *Neuroanatomy of the Auditory System* and *Physiology of the Auditory System*. The Institute has also supported the publication of a number of texts, including: *Index-handbook of Ototoxic Agents, 1960-1971*; Biblio-Profiles (including *Homotransplantation*, *Auditory Physiology*, *Otitis Media*, *Surgical Treatment of Deafness*, *Viral Infection and Hearing*, *Neuroanatomy of Speech*, and *Rehabilitation of Language Disorders in Children*); research bibliographies; and a directory, *Information Sources in Hearing, Speech and Communication Disorders*. Part I: Publications; Part II: Organizations.

Available also from NINCDS are the following publications: *Human Communication and Its Disorders: An Overview--Monograph 10*; *Reading Forum--Monograph 11*; *Learning to Talk*; and in the *Hope through Research* series, the following: *Hearing Loss*, *Dizziness including Meniere's Disease*, and *Acoustic Neuroma*.

NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

Public Law 89-36 authorized the Secretary of the Department of Health, Education and Welfare to enter into an agreement with an institution of higher education for the establishment and operation of the National Technical Institute for the Deaf (NTID). The Rochester (N.Y.) Institute of Technology (RIT) was selected as the sponsoring institution. NTID is a residential facility offering postsecondary vocational education and technical training to deaf persons in order to prepare them for successful employment, a training center for preparing professional manpower to serve the nation's deaf population, and a research and demonstration center to help reduce the economic, educational, communication, personal and social negatives of deafness.

In FY76, NTID reached a full-time equivalent enrollment of 780 deaf students. The current faculty and staff including instructional, instructional support, clerical, administrative, research, and training personnel, numbers 278. NTID's research activities are being heightened in FY76 as a result of what has been learned from operations in the new facilities and the results of students' progress and subsequent job success. In addition, 1440 other persons were provided with professional training to prepare them to work with deaf people.

The full-time equivalent enrollment of deaf students in FY77 will reach 940. All students are enrolled in curricula designed specifically to lead them to jobs upon graduation. Of the students served, 254 are expected to graduate during FY77 and be placed in jobs. Training in: 1) sign language programs for personnel who work with deaf students in a variety of capacities; 2) technical subject interpreting for interpreters; 3) graduate internship and in-service programs for graduate students, faculty, and staff; and intensive short-course workshops in which new methods developed and proven at NTID are presented to professionals in the deaf education and related fields. Applied research will focus on questions designed to provide for program enhancement. Some 37 projects on the modes, measurements, and improvement of communication skills of deaf students will be carried out. Fifteen other research projects directly oriented to improving the career development process of NTID will be conducted.

The obligations for fiscal years 1973-77 are as follows:

	1973 Actual	1974 Actual	1975 Actual	1976 Estimate	1977 Estimate
Salaries and expenses	$5,308,000	$5,826,000	$ 8,767,000	$10,980,000	$14,547,000
Construction	1,915,000	1,400,000	1,981,000	---	---
Total	7,223,000	7,226,000	10,748,000	10,980,000	14,547,000

GALLAUDET COLLEGE

Gallaudet College: Gallaudet College, established in Washington, D.C. by an Act of Congress in 1857, has as its purposes to provide a liberal arts undergraduate education program for the deaf, a tutorial school for deaf students who need such training to qualify for college admission, a graduate school program in fields related to deafness, and a continuing education program for deaf adults. In 1976, an estimated 1074 undergraduates and 239 graduate students will attend the College.

In order to promote student development, the College offers a wide variety of learning experiences and instructional options, mediated instruction, significant interaction with the larger society, and experiences which encourage growth toward self-fulfillment, including participation and practice in decision making. In addition, the College offers technical assistance to outside organizations and agencies and services to deaf individuals and persons concerned with the needs of the deaf.

Model Secondary School for the Deaf: Public Law 89-694 provides for the establishment of day and residential facilities for the secondary education of young persons who are deaf in order to prepare them for college, other advanced training or employment. The Public Law authorizes the Secretary, after consultation with the National Advisory Committee on Education of the Deaf, to enter into construction of such a school. The agreement was signed in May 1969. The completed school will serve residents of the District of Columbia and nearby states of Virginia, West Virginia, Maryland, Pennsylvania, and Delaware. In 1976, MSSD will have an estimated enrollment of about 171 students.

The permanent facilities for the Model Secondary School for the Deaf (MSSD) are presently being constructed on the campus of Gallaudet College. The first phase of construction, including the academic building, will be completed in FY 76. The six residence halls are scheduled for completion in FY 1977.

In one of the boldest experiments in the history of American education, students and staff have come together in a school to seek new ways in which today's young deaf students may be educated toward more productive and meaningful lives. An open laboratory school which employs computer-assisted education, educational television, and individualized instruction, the MSSD is a promise of things to come for schools for the deaf throughout the country. It is expected that the MSSD will provide an exemplary secondary school program to stimulate the development of similarly excellent programs throughout the Nation.

Kendall Demonstration Elementary School: Under P.L. 91-587, Gallaudet College was authorized by Congress to operate Kendall Elementary School as a national demonstration school for the deaf. In 1976 approximately 182 children will attend the school from the Washington, D.C. area.

As a demonstration school, KDES is attempting to develop an exemplary educational program for children from the onset of deafness through the age of 15. The School also provides for a diagnostic center and a parent education program. Because of its special focus, Kendall School is also becoming a source of important research on the learning problem of young deaf children.

The obligations for fiscal year 1973-77 for Gallaudet College are as follows:

	1973 Actual	1974 Actual	1975 Actual	1976 Actual	1977 Estimate
Salaries and expenses:					
Gallaudet College	$8,779,000	$10,218,000	$12,185,000	$14,513,000	$17,576,000
Model Secondary School	3,101,000	3,975,000	4,445,000	5,498,000	7,299,000
Kendall Demonstration School	1,905,000	1,995,000	2,412,000	2,792,000	3,237,000
Construction	14,495,000	9,473,000	2,306,000	20,398,000	15,575,000
Total	28,280,000	25,661,000	21,348,000	43,201,000	43,687,000

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

Hearing and Speech

The Office of Child Development, established in 1969, has advocacy and leadership responsibility for all children, including handicapped children. In line with this responsibility, OCD develops standards and guidelines for health programs and provides technical assistance to State, public and private agencies in an effort to help handicapped children. Within the Office of Child Development, the Bureau of Child Development Services administers Project Head Start, a comprehensive demonstration program for preschool children from low-income families. One of the key components of every Head Start program is the provision of health services, including health education, health screening and the treatment of identified illnesses and conditions. These services are also provided by Head Start demonstration programs, such as Home Start, Parent and Child Centers, and Child and Family Resource Programs.

The goal of the health component of Head Start and all its demonstration programs is to identify and coodinate existing health services to insure provision of health care to preschool children and their families. Head Start centers provide complete care to preschool children and their families. Head Start centers provide complete medical examinations, including visual acuity and hearing tests, and all programs focus on the early identification of health problems. During FY 1974, a pilot effort was launched in 200 Head Start programs to develop ways to insure maximum use of Medicaid Early and Periodic Screening, Diagnosis and Treatment Services for eligible children 0-6 years of age.

Head Start has always had a policy of encouraging enrollment of handicapped children, including those with speech and hearing defects. For FY 1977 Head Start will continue to assure, that 10 percent of the enrollment opportunities in each State are available to handicapped children. This is in accordance with the legislative mandate contained in P.L. 93-644, the Community Service Act of 1974. Prior to FY 1976 Head Start had implemented a policy of making 10 percent of the enrollment opportunities nationwide available to handicapped children.

As part of the new focus on the handicapped, Head Start programs are developing Speech, Language and Hearing Programs that make use of speech and hearing clinicians and of outside professional personnel in local clinics, centers and agencies. A special manual on the Speech, Language and Hearing program, recently developed for Head Start personnel, outlines a language and communications skills program for non-handicapped children as well as those with defects requiring professional treatment.

In addition, 14 experimental projects demonstrate new approaches to serving handicapped children in Head Start. Eight of these projects are operated by Head Start programs and six are early childhood projects jointly funded by OCD and the Bureau of Education for the Handicapped (BEH) in the Office of Education. Two of the joint OCD/BEH projects focus on speech and hearing handicapping conditions.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON JUVENILE DELINQUENCY

A REPORT TO THE
HOUSE COMMITTEE ON APPROPRIATIONS

Obligations for Programs on Juvenile Delinquency

	1974 Actual	1975 Actual	1976 Estimate	1977 Estimate
OFFICE OF EDUCATION:				
Elementary and Secondary Education				
Title I.............	$26,812,421	$26,618,141	$ 29,533,162	$30,000,000
Title III...........	660,000	594,000	330,000	---
Vocational and Adult Education............	2,000,000	3,500,000 1/	3,500,0001/	3,500,0001/
Library Resources........	400,000	300,0002/	300,0002/	---
Higher Education........	30,000	107,000	-0-	-0-
Teacher Corps...........	3,000,000	1,381,305	2,900,000	2,900,000
Subtotal, OE..........	32,902,421	32,500,446	36,563,162	36,400,000
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION:				
National Institute of Mental Health.........	3,069,000 (3,617,000)3/	2,636,000 2,740,000)3/	2,425,000	1,362,000
OFFICE OF HUMAN DEVELOPMENT:				
Rehabilitation Service Administration				
Basic State Grants..	15,800,000	17,000,000	17,000,000	18,000,000
Expansion Grants....	-0-	-0-	-0-	-0-
Rehabilitation research and demonstration.....	50,000	-0-	-0-	-0-
Subtotal, RSA.........	(15,850,000)	(17,000,000)	(17,000,000)	(18,000,000)
Office of Youth Development Youth Services Systems...............	10,000,000	5,000,000	-0-	-0-
Subtotal, OHD.........	25,850,000	22,000,000	17,000,000	18,000,000
TOTAL OBLIGATIONS.........	61,821,421	57,136,446	55,988,162	55,762,000

1/ Programs previously funded under Title III of the Elementary and Secondary Education Act and under the Vocational Education Act are consolidated under proposed consolidated education grants programs.

2/ Programs formerly funded under Title IV-A of LSCA must be maintained at the minimum of 1971 level.

3/ Includes 1973 released funds.

JUVENILE DELINQUENCY

Introduction

The Federal Government is deeply involved in programs to prevent and control juvenile delinquency and youth crime, as well as programs to rehabilitate youthful offenders. The Department of Health, Education, and Welfare is directly involved in several programs concerned with community-based rehabilitation, institutional services, and research and training.

The term juvenile delinquency is applied to a wide range of behaviors that young people engage in and to society's response to these behaviors, including both criminal and noncriminal behaviors. Criminal behavior includes those offenses of serious crime such as homicide, aggravated assault, forcible rape, robbery, and those of simple assault, forgery, drunkedness, drug abuse, disorderly conduct, and so on. Noncriminal behavior ranges from status offenses to dependency cases. Status offenses are offenses that would not be unlawful if engaged in by an adult (truancy, running away, curfew violations).

The youthful offender not only loses status and potential as he is drawn into the juvenile justice system but he becomes an item in the mounting cost of juvenile related crime. It has also been noted that youthful offenders have the highest recidivism rates.

Dealing with these problems within the Department of Health, Education, and Welfare are programs in the Office of Education; the National Institute of Mental Health in the Alcohol, Drug Abuse and Mental Health Administration; and the Rehabilitation Service Administration in the Office of Human Development. In 1975, OHD's Office of Youth Development phased-out its support of youth service systems which were delinquency prevention oriented. This was in accordance with the mandate of PL 93-415, the Juvenile Justice and Delinquency Prevention Act.

OBLIGATIONS FOR PROGRAMS ON JUVENILE DELINQUENCY

AGENCY	1973 ACTUAL	1974 ACTUAL	1975 ACTUAL	1976 ESTIMATE	1977 ESTIMATE
OFFICE OF EDUCATION					
Elementary and Secondary Education					
Title I	$28,793,863	$26,812,421	$26,618,141	$29,533,162	$30,000,000
Title III	660,000	660,000	594,000	330,000 1/	---
Vocational and Adult Education	2,000,000	2,000,000	3,500,000	3,500,000 1/	3,500,000 3/
Library Resources	300,000	400,000	300,000 2/	300,000 2/	---
Higher Education	29,699	30,000	107,000	-0-	---
Teacher Corps	2,500,000	3,000,000	1,381,305	2,900,000	2,900,000
TOTAL	$34,283,562	$32,902,421	$32,500,446	$36,563,162	$36,400,000

1/ Programs previously funded under Title III of the Elementary and Secondary Education Act and under the Vocational Education Act are consolidated under proposed consolidated education grants programs.

2/ Programs formerly funded under Title IV-A of LSCA must be maintained at the minimimum of 1971 level.

3/ Percentages of funds devoted to juvenile delinquency cannot be accurately determined.

OFFICE OF EDUCATION

REPORT ON JUVENILE DELINQUENCY

(Fiscal Year 1977)

Title I of the Elementary and Secondary Education Act of 1965, P.L. 89-10, was amended on November 3, 1966 by Public Law 89-750 to include education or educationally related services to children living in State and local administered institutions for Neglected or Delinquent children.

Grants are available to State agencies for those institutions which operate a school program and to local educational agencies for other public and private non-profit institutions for delinquents. Grants are based on applications which must describe the special educational needs of the youths in the institution and propose educational projects designed to meet the most crucial of those needs. While the Office of Education administers the provisions of the Act and provides program leadership, it is the State departments of education which are authorized by Title I to approve project applications.

In the 1975-76 school year, $25,375,075 will be allocated for 41,546 eligible delinquent children living in 564 State administered institutions. At the same time, approximately $4,200,000 will be allocated for 21,120 eligible delinquent children in 445 locally administered institutions. These children are to be served through grants made to local school districts.

Since the inception of P.L. 89-750, a major effort has been made to expand and improve educational programs for institutionalized children and return those children to their families and communities with modified concepts about education, themselves and society. The emphasis in programs has been toward improved, more relevant curriculum designed for the unique needs of the children, better teaching, and greater cooperation among institutions, schools and community. There is also an acute awareness of the fundamental need for relevant teacher and other related staff training as the major step for improving education in the institutions. Effective educational aid received by these children now is much less costly, to the taxpayer, in the long run. Growing relief payments and the need for ever-expanding law enforcement facilities are inevitable results if delinquent children continue unaided into adulthood as highly unproductive and disruptive products of the poverty cycle.

Actually, there are 115,007 institutionalized neglected and delinquent children in State and local institutions who were counted for computing allocations for 1976. With continued and increased funding, the opportunities are great for this program to develop more appropriate programs for the children while discovering more effective general approaches to compensatory education. The laboratory-like characteristics of education in institutions, the nation-wide scope of the relatively small and more easily managed program, and its involvement with agencies and activities concerned mainly with poverty, crime and education are factors pointing to a high level of future success.

Public Law 89-10, ESEA Title III, Supplementary Educational Centers and Services, enables schools to provide programs presently unavailable to children, to raise the quality of educational services already offered, and to stimulate the development and evaluation of experimental elementary and secondary education programs to serve as models. Fifteen percent of program funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing.

Vocational Education Act. The vocational education reporting system does not collect data on juvenile delinquency. Information received from the States does indicate that the States are using increasing amounts of money and technical assistance in vocational education programs for delinquent youth residing in correctional institutions. Special projects for dropouts, many of whom might become delinquent without the self confidence that a salable job skill can give them, are operating in many States. Vocational education has the positive attribute of offering relevant education leading to a career objective, and hands-on activities without the emphasis on academics which may turn off students who are unable to meet certain of these standards. Therefore, it may be that vocational education has prevented possible delinquency on the part of many students from all income levels who want to be prepared for the world of work, be financially independent, and be able to receive the education they perceive as important to their future as adults.

In Maryland a new office occupation program was developed and funded to serve youth in the Department of Juvenile Services. A non-occupational program, vocational evaluation, was also developed by the Department of Juvenile Services and impelemented at the Forestry Camp in Western Maryland.

Also in Maryland funds were provided for maintenance of the approved vocational programs at Victor Cullen School and to support the position of vocational coordinator for the Division of Juvenile Services.

In Mississippi, 53 programs were operated in two juvenile correction centers as well as in public secondary schools. The programs included occupational orientation, skill training, and remedial-related services.

Under the Trade and Industrial Education Program in Ohio, guidelines for a two-year law enforcement program for the secondary level were developed and disseminated to all vocational directors in the State.

Also in Ohio, the Akron City Schools leased two facilities to provide new approaches to training and adjustments for 172 malcontented and disruptive girls and boys. These two facilities, several miles from the city, are open-environment settings to provide an informal and flexible adjustment and education programs. The programs are designed to meet the special social, academic, personal, as well as vocational and prevocational needs of the participating students.

The staff of the Wyoming State Department of Education has written and disseminated new materials and guidelines pertinent to occupational education to all schools (K-14) including the University of Wyoming and State youth correctional institutions.

These programs are generally planned and implemented in coordination with other agencies such as correctional, welfare, vocational rehabilitation, and employment service and provide vocational training for students in Federal prisons, in State and local juvenile correctional institutions, in detention homes, and in many elementary and secondary school settings. Additional services provided include occupational orientation, guidance and counseling remedial education, individualized instruction, and additional equipment and supplies.

Title I of the Higher Education Act of 1965 pioneered in bringing college and university resources to bear upon the community problem of juvenile delinquency and the prevention. As more substantial amounts of money became available through other programs in Health, Education, and Welfare and the Department of Justice, activities supported by Title I diminished. However, a few projects of an experimental nature are still supported and they include the training and counseling of youth in correctional institutions; and helping disadvantaged out-of-school young people to rediscover their academic abilities and pursue further training. Also some projects are for participants who must deal directly with the delinquents. In fiscal year 1975, an estimated $107,000 was applied to six juvenile delinquency projects with approximately 435 participants in 4 states. No funds have been released for the Title I program in fiscal year 1976 and none are requested for fiscal year 1977.

Under the Library Services and Construction Act (LSCA), Title I, projects are funded which benefit many juvenile delinquents whether they live in State or local institutions or in their own homes. Under this State-administered Act, public library services are extended in areas where they are inadequate; and libraries are improved in residential facilities operated or substantially supported by the State.

Increasingly, public libraries are developing outreach projects which take appealing multi-media materials into inner city neighborhoods, migrant camps, detention homes, half-way houses and other places not usually reached by more conventional library services. Bookmobiles, storefront libraries and "instant" libraries are attracting former "non-users", including many young people. Libraries with outreach services cooperate effectively with other agencies in conducting crime prevention, drug education and post-release programs.

Since 1968, juvenile correctional facilities have been among the State institutions eligible for grants under LSCA. Usually an institution receives a grant for one or more years for the purpose of developing its library, extending services to all residents, and providing qualified staff. The institution or its parent State department then assumes responsibility for financing and administering the library and the State library agency continues back-up services, i.e., consultative and training, and interlibrary loan of books, films and other materials.

A report from Arkansas shows that four correctional units for young people were supported in part with funding from LSCA. These units were visited by State consultants and special staff an average of five times during the year. Purposes of visits were to provide technical assistance and special programs for the residents. Using filmstrips, records, cassettes, and picture story study prints from the State Book Center, programs such as book talks, "sing-along " discussions, and story hours were given. A list of the audio-materials purchased with LSCA funds (available from State Center) was sent to all the institutions with special encouragement to borrow them. Progress was seen throughout the State.

Of the three training schools, two for boys and one for girls, the boys' training schools have certified school librarians. The teacher/librarian of the girls' school has 12 hours of library science training and is not yet certified. None of the schools has adequate space, but the Boy's Training School at Wrightsville is building a school addition containing a large library. The libraries are included in their schools' budgets. Each of the boys' schools have regular programs of film strips, book talks, and story hours for younger boys.

The Rehabilitation Center at Hot Springs added a part time librarian with an MLS degree. This enables the library to give better service to its patrons. The library has a GED collection which is used extensively. Attendance and circulation have steadily increased. The library is included in the institution budget.

A report from Florida shows the Desoto Correctional Institution (DCI) in Arcadia moved into larger quarters with a 30% increase in floor space.

The added space is utilized [illegible] an audiovisual section and a newspaper/magazine reading area. About 70 percent of the equipment and materials were ordered under an LSCA grant. The audiovisual section, accomodates 16-20 men with individual carrels and small group participation tables. Equipment includes microfilm readers, tape players with instant replay features, stereo disc players, 8mm loop projectors and filmstrip and slide projectors. These materials support the equipment "systems" with a variety of offerings which span the interest curve from non-reader to college levels, including programmed courses in beginning and intermediate Spanish.

The DCI library is open every day. Educational and vocational staff members make possible a 70 hour per week schedule. In addition to regular assignments, inmate library aides assist the staff during the evening and on weekends.

Teacher Corps corrections projects, as well as standard projects, operate over a two-year period.

In fiscal year 1975, two 8th cycle projects, The University of Southern California and the Union of Experimenting Colleges and Universities (Antioch College, Ohio), received their second year of funding for activities which began in FY 1973. Project emphasis was on training interns to work with inmates. In addition, two new 10th Cycle projects were funded with the Balitmore Public Schools, Maryland, and Loretta Heights College, Colorado. They represent a policy of movement away from prisons as the target population. The projects' focus is on dealing with the problems of prevention, incarceration and re-entry into the school community. Regular teachers at both facilities are involved in an inservice training program with heavy concentration on the teacher-counselor role in working with troubled youth.

In fiscal year 1976, four 9th cycle projects received their second year of funding. Projects were located at Arizona State University, The University of Southern California, New Jersey State Department of Education and the Vermont State Department of Education. In addition, it is expected that in the 11th cycle, five new sites will be funded to function within the framework of a public school system's elementary/secondary program or within the school program of a state or local juvenile justice system which could include academic and vocational schools inside detention centers, within closed institutions, or in community-based alternatives to juvenile institutions. In addition, projects will demonstrate field-based training designs as well as the potential for regular teachers to receive inservice training along with Teacher Corps teams.

In fiscal year 1977, 11th cycle projects will be funded for their second year activities. It is expected that 12th cycle projects will be very similar to 11th cycle. Teacher Corps will be seeking opportunities for linkage with other federal funding sources working in the corrections field. These efforts will be in addition to those made during 11th cycle.

Collaboration with Other Agencies

To facilitate and to maintain close contacts and liaison with other Federal and private agencies, NIMH staff meet with representatives to discuss programs and policies in the crime and delinquency field. Of particular importance is the continuing and on-going consultation and collaboration NIMH staff have had with representatives of the Law Enforcement Assistance Administraion, especially in reference to the implementation of the Juvenile Justice and Delinquency Prevention Act of 1974 (P.L. 93-415). Other activities include consultation with such agencies and programs as: The Office of Youth Development (DHEW), the Manpower Administration of the U.S. Department of Labor, the U.S. Office of Education, the National Institute of Education, the National Institute on Drug Abuse, and the National Institute of Alcohol, Abuse and Alcoholism.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health

Obligations for Programs on Juvenile Delinquency

1973 Actual	1974 Actual	1975 Actual	1976 Estimate	Transition Quarter Estimate	1977 Estimate
$5,250,000	$3,069,000 ($3,617,000)1/	$2,636,000 ($2,740,000)1/	$2,425,000	$606,000	$1,362,000

1/ Includes 1973 released funds.

JUVENILE DELINQUENCY

Juvenile delinquency continues to be a major social problem in the United states. Almost half of all persons arrested in 1974 for serious crimes (e.g., homicide, robbery, burglary) were under 18 years of age; three-quarters of such persons were under 25 years of age.

Understanding the causes of delinquency, and developing effective remedies, is a complex task. Delinquent behavior stems from complex interactions of environmental, biological, psychological, social, cultural, moral, and other factors. In addition, whether or not a particular pattern of behavior is considered "delinquent" depends on societal norms and reactions which may differ considerably from one jurisdiction to another. For example, a particular act may be viewed as delinquency in one jurisdiction but as tolerable , though annoying, juvenile behavior in another. Much may also depend upon who the offending juvenile happens to be, the circumstances under which the offending behavior occurs, the persons who observe or learn about the behavior, and the ability of social agencies other than the police and the courts to cope with the behavior in question. Juvenile delinquency is accordingly a problem of relevance to wide ranges of public and private agencies including those with responsibilities of meeting the health, educational, and welfare needs of society.

The National Institute of Mental Health has a mandate under the National Mental Health Act of 1946 and subsequent legislation to undertake and foster research on problems of human behavior related to mental illness and mental health, to promote the useful social application of findings from such research, to train persons in matters related to mental health, and to assist states and communities in the use of the most effective methods of preventing, diagnosing, and treating mental health problems. The Center for Studies of Crime and Delinquency is the focal point in NIMH for research, training, and related activities specifically concerned with problems of mental health reflected in various types of deviant, maladaptive, aggressive, and violent behaviors that frequently involve violations of the criminal or juvenile law. The Center's conceptualization of its mission further requires that attention be given both to the individuals who engage in the behaviors mentioned, and to the larger social contexts in which the behaviors develop, are observed, and are responded to in accordance with prevailing social norms and practices. The Center program thus encompasses problems in areas of individual and community mental health that are also of concern to law enforcement agencies, criminal justice agencies, schools, social welfare agencies, and other public and private agencies at national, state, and local levels.

The program activities of the Center in the juvenile delinquency area include the development of needed scientific knowledge on sources and patterns of delinquency-related behaviors; the development, testing, and evaluation of new program models for handling and coping with such behaviors by means short of institutionalization; and the development of improved educational (training) strategies for the more effective application of behavioral and social science knowledge to the solution of delinquency problems at national, state, and local levels. The Center's program is carried primarily in the form of research and training grants which are awarded to persons who submit successful applications for support of work in fields related to crime, delinquency, deviant behavior, individual violent behavior and law and mental health interactions.

Needed Knowledge on Delinquency-Related Behavior

Basic to the development of improved means for the prevention, control, and treatment of delinquency-related behaviors is the need for more precise knowledge on these behaviors. Such information can add significantly to scientific understanding of psychological and social forces that affect mental health and behavioral performance of individuals and groups. In addition, such information can add greatly to the understanding of social forces that operate on individuals and which have a major role in developing policy decisions with respect to the handling of individual behaviors that are perceived as troublesome, offensive, threatening, or harmful to others.

Juvenile Behaviors

Several studies using longitudinal, age-cohort, self-report, and survey research techniques are providing important information on the dimensions of delinquent behavior.

Results from a National Survey of Youth comparing self-reported delinquent behavior among 13 to 16 year olds in 1967 and 1972 show that the amount of delinquency has not changed but that the style has. Boys in 1972 reported less delinquent behavior than their peers in the 1967 survey; but they admitted to markedly different kinds of offenses. Specifically, more of the 1972 male respondents reported more frequent use of illicit drugs--mostly marijuana--than did the 1967 respondents, but less larceny, threatened assault, trespassing, forcible and nonforcible entry, and gang fighting. The girls in 1972 also reported greater use of drugs--mostly marijuana but including alcohol--than girls did in 1967, while reporting less larceny, property destruction, and breaking and entering. However, the decline of the latter types of offenses did not balance the greater use of drugs. The results of the study thus suggest a growing involvement by girls in delinquent behavior.

A longitudinal study is investigating patterns of rural delinquency and subsequent rural crime. Findings with respect to all youths who were sophomores in 1964 in all of the high schools in a non-metropolitan Oregon county are being compared to the results of another NIMH-funded study which has investigated patterns of delinquency among Philadelphia high school boys. The most startling discovery from the Oregon study has been the unexpectedly high rate of delinquency among the rural high school students between the ages of 16 and 18 years. Fully one in four had an official record with the county juvenile department, and more than 50 percent had been charged with committing one or more felonies prior to their 18th birthday. Another unexpected finding was that many of the rural youths passed through their middle teens without being charged with an offense, but then appeared on official records as adult offenders. This finding does not accord with the commonly held assumption that adolescents who commit serious juvenile offenses are the population group most likely to become adult criminals as well. On the other hand, the study also indicated that the timing of involvement in juvenile delinquency might be a better predictor of adult criminality than had previously been thought. It was found that 73 percent of the boys who committed officially recorded delinquent acts before and after the second semester of their sophomore year in high school went on to commit offenses as young adults. By contrast, only 53 percent of the boys who committed their first officially recorded delinquency after completing the first sophomore semester became young adult offenders.

Another longitudinal study is investigating relationships between childhood experiences and subsequent adult anti-social behavior. The subjects are men, now in their mid-forties, who were the original subjects of the Cambridge-Somerville Youth Study. This was a pioneer delinquency prevention project in which the homes of approximately 250 boys in the cities of Cambridge and Somerville, Massachusetts, were visited approximately two times a month during the years 1939 to 1945 by social workers who then wrote reports that provide a fairly comprehensive picture of the childhoods of the boys over a five-year period. The boys averaged nine years of age when the study began; half of them had been identified as potential delinquents, the other half were considered unlikely to become delinquent. The aim of the study is to determine whether anti-social behaviors that occur in later adulthood are related to the same childhood factors as anti-social behaviors which occur in young adulthood and adolescence.

A fourth study involves a national probability sample of approximately 2,100 youth, ages 11 through 17, who will be interviewed in 1976 and following years with respect to involvement in delinquent behavior. This study will provide ongoing estimates of the extent and seriousness of delinquent behavior as reflected in youth self-reports, describe age and group differences in frequency and forms of such behavior, and compare incidence, patterns, and correlates of delinquent behavior as reflected in self-reports and in police reports. In addition, the study will involve identification of those variables which appear to account for observed changes in levels and patterns of involvement in delinquent behavior over time.

A fifth study is seeking to identify and distinguish etiological characteristics of juvenile offenders who have engaged in five different types of delinquent behavior -- viz., vandalism, theft, running away, violence against persons, and drug use. This study involves secondary analysis of five large sets of data on juvenile delinquency generated by previous studies whose results have not been systematically compared. In addition, it is hoped that by explicating different behavior profiles associated with five different types of juvenile offenses, the study will generate recommendations for more effective prevention and early intervention strategies.

Violent Behaviors

President Ford in a message sent to the Congress in 1975 noted that crimes of violence have increased in the United States and that the nation has been singularly unsuccessful in its attempts to prevent such crimes. The problems of individual violent behavior is also one of extraordinary difficulty for mental health researchers and practitioners: no psychological instrument has yet been devised which can satisfactorily predict individual violence, and existing treatment procedures have not been very satisfactory. The NIMH crime and delinquency program accordingly supports a number of basic research projects which are aimed at improving scientific understanding of factors associated with individual violent behavior.

One important area of scientific inquiry concerns the possibility that individuals with the 47,XYY or 47,XXY chromosome abnormality may engage disproportionately in violent behavior. NIMH is supporting several studies to determine the extent (prevalence) of these chromosomal abnormalities in different population groups and the relationship, if any, between such abnormalities and involvements in anti-social behavior.

Another study is aimed at contributing to improved understanding of interactive effects of heredity and environment on officially recorded delinquency and crime. The study is being conducted in Denmark where a unique national system of centralized birth-to-death record keeping on all citizens makes large study samples feasible and economical. One part of the study is concerned with the life histories of some 14,000 adopted children whose biological fathers can be identified in 90 percent of the cases. Since adoption is often a process by which individuals are reared apart from biological relatives, studies of adoptees are a means of ascertaining possible genetic factors in the etiology of individual violence after influences of various environmental factors are accounted for. The other part of the study is concerned with the life histories of some 5,000 identical (one-egg or monozygotic) and fraternal (two-egg or dizygotic) twins. The logic for this study is that since monozygotic twins have identical genotypes (barring mutations), any dissimilarity between members of the pair must be due to environmental influences, whether uterine or postnatal. Fraternal twins differ genetically but have a number of environmental similarities -- e.g., birth rank and maternal age. Studies of both types of twins are thus another means of clarifying the possible effects of genetic contributions on violent and criminal behavior. For example, results to date of the twin research have indicated that identical twins of both male and female criminals are much more likely to be involved with the law than is the case with fraternal twins of such criminals.

A third study, also being conducted in Denmark, involves a sample of 9,000 children and is aimed at assessing relationships between pregnancy and birth complications and subsequent violent and other anti-social behavior. Earlier work by the investigator has indicated the possible importance of such peri-natal factors in contributing to subsequent psychiatric breakdowns among children at high risk for schizophrenia.

Societal Responses to Delinquent Behavior

Several NIMH research projects are aimed at improving understanding of different social policies with respect to the application or non-application of legal sanctions to delinquent behaviors.

A study in Arizona is exploring how reactions to delinquency on the part of police, probation officers, etc., are affected by different levels of tolerance for deviant juvenile behaviors which exist in three Arizona communities. The study is also investigating the extent to which adolescents, adults, and law enforcement agents hold similar and divergent views with respect to the particular types of legal reactions considered appropriate for different forms of delinquent behavior. Another important feature of the study is the attention given to female as well as male juvenile delinquency. This part of the study is intended to ascertain possible significant differences in community and law enforcement reactions to particular types of delinquent behaviors depending on whether the behaviors in question are committed by females or males.

Another study is concerned with ascertaining the effects of different organizational strategies for the management of juvenile offenders and according to whether, after an initial societal response involving an arrest, the offenders are channeled into referral agencies for "treatment" or are given some alternative disposition involving "less" societal reaction. The investigator's perspective on labeling theory suggests that whatever form the societal reaction may take, it will be interpreted and analyzed by the juvenile offenders in ways that will increase or decrease the likelihoods of future involvements in delinquent activity. The purpose of the study is therefore to measure and relate impacts on offenders of a sequence of variables starting with the initial actions taken by police, the application of labels by persons subsequently in contact with the youth, the acceptance or rejection of these labels by the youth, and the subsequent recidivism or conforming behavior on the part of the youth.

A third study is concerned with evaluating the effects of three alternative processing practices of police with respect to juvenile offenders: (1) screening without further legal action or treatment; (2) diversion leading to some treatment or service outside the criminal justice system; and (3) referral to juvenile court including treatment and services within the justice system. It is hypothesized, based on labeling theory, that youths who are diverted or screened will experience less negative labeling than youths who are retained in the justice system. It is further hypothesized that youths who are diverted will experience more positive change than youths who are screened or retained in the justice system. The study is being conducted in three cities (San Antonio, Kansas City, Boulder) in order to assess impacts of the police processing practices in research sites characterized by different degrees of urbanity and population mix.

Community-Based Treatment Models

One of the most promising innovations in the delinquency field during recent years has been the increased use of community-based programs as alternatives to institutionalization of children who persistently engage in delinquent and related problem behaviors. There is an urgent need, however, for improved treatment technologies which can be applied to these children in their own communities. The NIMH program in crime and delinquency accordingly has given high priority to the generation of new treatment models which can be applied by parents, teachers, mental health professionals, and other qualified and concerned persons in a variety of community settings.

The Achievement Place project in Kansas has involved the development and testing of an intensive community treatment program for adolescent youth as an effective and economical alternative to institutionalization. Achievement Place is a community-based, family-style residential group home for six to eight youths between 11 and 16 years of age. The therapeutic approach and rehabilitative techniques utilized in the home by the "teaching parents" have been derived from basic learning principles developed by experimental psychologists and utilized in a wide variety of fields. These learning principles are used to influence the social and interpersonal behavior of the youngsters, their school behavior, their relations with parents and peers, and their development of self-control skills. The homes establish close ties with local juvenile courts, departments of welfare, schools, and parents. The homes also involve the close and active involvement of an advisory board drawn from members of the local community in the planning and operation of the program. To meet the wide demand for application of the model, a training component has been developed to train "teaching-parents." Likewise, a "how-to-do-it" manual and other user-oriented materials have been produced to facilitate ready utilization of the model. As of December 1975, 47 homes based on the Achievement Place model were known to be operating in 12 states. The homes work with delinquent boys and girls, the mentally retarded, and adolescents with drug problems. Support for the homes has come from State agencies, local groups, the Law Enforcement Assistance Administration and the National Institute on Drug Abuse.

An investigator in Oregon is engaged in the development of a family training model aimed at helping parents and mental health clinicians to cope with socially aggressive and "out of control" children who, if not given adequate treatment, may engage in more serious delinquent behaviors as they grow older. The research is predicated on the notion that improvements in parenting skills can successfully change delinquent and pre-delinquent behavior. The procedures under development are derived from social learning theory based on the assumption that behavior is controlled by its contingencies -- i.e., by the consequences that follow. Parents are accordingly taught that the behavior of their children is a close reflection of the reinforcing contingencies provided within the family, and that appropriate changes in such contingencies can alter and eliminate problem behaviors by their children. Instruction is provided to parents in the development of skills needed to engage in careful observation of problem behaviors by their children, select appropriate change goals and objectives, decide on steps which their children need to take in order to achieve the desired results, and identify contingencies needed to achieve and maintain good behavior by their children. The research is also aimed at extending the treatment model for use with adolescent delinquents and their parents.

Another project is concerned with programs which public junior high schools can use in meeting needs of disruptive and under-achieving students. Originally developed and tested in a suburban school, the programs have since been applied in a more rural setting and in an inner city school characterized by a high proportion of students from broken and economically deprived homes. The model is based on the assumption that children and youth need to acquire a basic set of interpersonal and academic skills in order to function competently in society, and that most frequently it is a deficiency in these skills that gets youngsters into trouble.

Training

NIMH is concerned with training mental health professionals and behavioral and social science researchers in the fields of juvenile delinquency and related deviant behavior. The emphasis has been on developing more effective program models to meet specified social goals and related training needs. All such models must therefore include an evaluation component that will permit an assessment of the effectiveness of the training provided.

Growing out of the Achievement Place group home treatment model, to which previous reference has been made, is a training project aimed at assisting husband and wife teams to function as surrogate parents ("Teaching Parents") in these homes. The trainees learn how to set up an Achievement Place home in a new community setting, how to administer the program, and how to motivate the youths in their care to adopt more positive social behaviors. The trainees are also provided instruction on how to counsel and work with the natural parents of the youths within their care, and on how to establish and maintain good relations between the group home and the local community.

Another program is providing behavioral training for foster parents and potential foster parents of unmanageable or delinquent children. Hitherto, there have been few programs which have attempted to train foster parents to care for especially difficult problem youths, and the number of parents who will currently accept an adolescent foster child who has been in trouble is very low. The program seeks to determine whether the training process enables the foster parents to be more effective and whether this will increase the number of prospective foster parents willing to take a troubled youth into their family. The training is based on behavioral principles and procedures and is aimed at providing the sort of structure and immediate relevancy that parents need in dealing with problem youth.

Legal problems of juveniles are too often ignored by the practicing bar. In an effort to address this manpower need, another project is providing law students with clinical training in the representation of juveniles in hearings on delinquency, neglect, dependency, and supervision petitions. The primary goal is to increase the number of new lawyers who have experience representing children, who feel committed to such work, and who will contribute over time in improving the quality of the legal system as it relates to juveniles.

Numerous social action and service programs have been supported by State and local agencies to meet problems associated with delinquency. In addition, various groups in the community such as youth and minority group members, have developed informal programs designed to treat their members whose behaviors are defined as deviant by the larger society.

While both formal and informal organizations and groups may provide services and generate innovative methods of treatment, rarely do these programs provide for adequate and systematic evaluation to assess their efforts. One reason for this lack of assessment has been the absence of qualified manpower. Typically, agency evaluation efforts are more concerned with basic statistics and budgetary accounting than with more systematic and substantive evaluation of program effectiveness. In order to address this need, the NIMH is supporting two projects to train students in a specially designed 2-year Master's degree program, with particular concentration on evaluative skills relevant to social action programs related to problems of crime, delinquency, and social deviance. All training programs, with the exception of postdoctoral fellowships, are proposed for phase-out in FY 1977.

Monograph Series

The NIMH Center for Studies of Crime and Delinquency has been especially concerned about the need for timely dissemination to the public of high quality and up-to-date information concerning important trends and issues in the crime and delinquency field.

One series of short monographs is intended to inform administators, decision makers, community leaders, and other interested persons about research results of mental health significance. These monographs point to gaps in knowledge and suggest directions for future program development. This monograph series has included: The Juvenile Court: A Status Report; Diversion from the Criminal Justice System; Community Based Correctional Programs: Models and Practices; Graduated Release; Civil Commitment of Special Categories of Offenders.

Another series of longer monographs, produced under contract by a number of outstanding authorities, has been devoted to the in-depth discussion of important issues in the crime and delinquency area. Several of these mongraphs have been adopted for use in educational courses given by colleges, universities, and police academies. This monograph series includes the following titles: Perspectives on Deterrence; Legal Sanctioning and Social Control; The Functions of the Police in Modern Society; Instead of Court: Diversion in Juvenile Justice; Development and Legal Regulation of Coercive Behavior Modification Techniques; Correctional Treatment in Community Settings; Not the Law's Business: An Examination of Homosexuality, Abortion, Prostitution, Narcotics, and Gambling in the United States; Competency to Stand Trial and Mental Illness; Routinizing Evaluation: Getting Feedback on Effectiveness of Crime and Delinquency Programs; The Contemporary Woman and Crime; Mental Health and Law: A System in Transition; Strategic Criminal Justice Planning; and Observing the Law: Applications of Field Methods to the Study of the Criminal Justice System.

A series of Research Reports has also been prepared in order to make information on specific NIMH research projects of unusual interest readily available to researchers, program administrators, and other persons involved in the crime, delinquency, and mental health fields. Items thus far published include: Achievement Place: A Model for Delinquency Treatment; Helping Schools Help Children; The St. Louis Experiment: Treating Antisocial Children in the Open Community; Teenage Delinquency in Small Town America; and Predictive Sentencing: How Best to Rehabilitate Teenage Traffic Offenders.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

Fiscal Year	1973	1974	1975	1976 Estimate	1977 Estimate
Basic State Grants	$15,600,000	$15,800,000	$17,000,000	$17,000,000	$18,000,000
Expansion Grants	450,000	-	-	-	-
Rehabilitation research and demonstrations	700,000	50,000	-	-	-
Total, RSA	$16,750,000	$15,850,000	$17,000,000	$17,000,000	$18,000,000
Office of Youth Development					
Youth Service Systems Program	10,000,000	10,000,000	5,000,000	-0-	-0-
Total, OHD	26,750,000	25,850,000	22,000,000	17,000,000	18,000,000

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

JUVENILE DELINQUENCY

Many State rehabilitation agencies have developed programs to provide physically and mentally handicapped delinquents with the services they require to make an adequate vocational adjustment in the community. These services are usually provided through the Basic Support program in coordination with public correctional agencies, institutions, probation offices, and the courts.

In Alabama, a cooperative agreement between the Board of Corrections and the State rehabilitation agency whereby prison inmates are housed with other rehabilitation clients in a community facility has had successful results. Incarcerated individuals are being afforded an opportunity to participate in vocational rehabilitation programs in many areas of that State. The Texas rehabilitation agency has been working with the Office of Juvenile Rehabilitation to develop increased participation of such other resources as community colleges, halfway houses, private employers, contractors for job placement of the offender, and local government correctional programs. In North Carolina a cooperative program has been established for the youthful offender who is mentally retarded, which combines prevocational and personal adjustment services with specialized counseling and recreational services.

Through its Training program, the Rehabilitation Services Administration is supporting a project in rehabilitation social work at Marywood College, Pennsylvania. The project trains rehabilitation social work students in correctional settings, with particular stress on meeting the vocational needs of the severely handicapped offender.

Office of Youth Development

In 1975, 40 project grants for local Youth Service Systems were awarded to phase-out the Youth Service System Program authorized by the Juvenile Delinquency Prevention Act, which expires June 30, 1975. Technical assistance, training and information services necessary for the phasing-out of the entire program were also provided.

Prior to 1976, the Office of Youth Development assisted States and localities to coordinate their various programs and resources available for the prevention, treatment, and control of juvenile delinquency. This was accomplished through the award of grants or contracts to public or nonprofit agencies to implement coordinated youth service programs. Along with funding coordinated youth service systems, training and technical assistance is furnished through grants or contracts to assist in the development and operation of youth service programs and in matters relating to the prevention of delinquency. Since 1971, the Youth Development Program supported 103 youth service systems (YSSs) throughout the Nation. These provided integrated services to allow agencies to work together to achieve common objectives.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

House Appropriations Subcommittee Supplementary Data

(Fiscal Year 1977 Congressional Hearings)

MENTAL RETARDATION PROGRAMS

Prepared by: The Office for
Handicapped Individuals

February 1976

COORDINATION OF MENTAL RETARDATION PROGRAMS

The thrust of the Federal commitment in combating mental retardation depends upon a highly coordinated interagency effort. Coordination is vitally important in administering the many varied and diverse programs serving the retarded. It is a fact that mental retardation cannot be confined to any single health, education, rehabilitation or welfare program, or any one disciplinary group. A coordinated program, therefore, must provide a broad spectrum of activities designed to attack the problem of mental retardation wherever it touches the lives of people.

During Fiscal Year 1976, an estimated $1.9 billion will be obligated by the Department of Health, Education, and Welfare for mental retardation programs. These programs cover most aspects of the retarded person's life. They range in diversity from maternal and infant care to income maintenance for the aged retarded. Many agencies of the Department administer programs which affect the mentally retarded; it is extremely important that these efforts be focused and targeted so as to prevent duplication and gaps in program services.

The 1962 Report of the President's Panel on Mental Retardation recognized the importance of coordination both at the national and local levels. The Report further endorsed the concept of a Departmental committee composed of agency representatives advising the Secretary on activities related to mental retardation. The concern of the Panel resulted in the strengthening of the Secretary's Committee on Mental Retardation in 1963. The Committee had previously been known as the Departmental Committee on Mental Retardation, since its establishment in March of 1955.

Over the next several years the mental retardation program of the Department was expanded and extended. In 1968, in a move designed to make the Secretary's Committee more responsive to prevailing needs, the Secretary reconstituted the membership of the Committee to include the top level executives of the Department with the Under Secretary serving as Chairman. In addition, Regional Office staff were also assigned to coordinate mental retardation Regional activities. The mission of the Secretary's Committee on Mental Retardation remained the same; i.e., the responsibility for coordination of the Department's programs and activities affecting the mentally retarded.

On January 25, 1972, the Secretary of Health, Education, and Welfare directed the establishment of the Office of Mental Retardation Coordination. This unit replaced the Secretary's Committee on Mental Retardation, and assumed responsibility for the functions of that office. The Office of Mental Retardation Coordination provided coordination and evaluation of the Department's mental retardation activities and served as a focal point for consideration of Department-wide policies, programs, procedures, activities and related matters relevant to mental retardation. The office also served in an advisory capacity to the Secretary in regard to issues related to the administration of the Department's mental retardation programs, and acted as liaison for the Department with the President's Committee on Mental Retardation.

On February 20, 1974, Secretary Caspar W. Weinberger announced the establishment of the Office for the Handicapped in the Office of Human Development. Legislative authority for the new office is defined in Public Law 93-112, "Rehabilitation Act of 1973," Title IV, Section 405. By authority of the Rehabilitation Amendments of 1974, the title was changed to Office for Handicapped Individuals.

In succeeding the Office of Mental Retardation Coordination, the Office for Handicapped Individuals organized to carry out its role to serve the handicapped while continuing to give necessary focus to the mentally retarded. All vulnerable populations became the concern of the new office. Priorities of the Office for Handicapped Individuals are:

To prepare a long-range projection for the provision of comprehensive services to the handicapped;

To continually analyze the operation of programs for the handicapped, and to evaluate their effectiveness;

To encourage coordination and cooperative planning among programs serving the handicapped;

To develop ways to promote the utilization of research related to the handicapped; and

To provide for a central clearinghouse for information and resources available to handicapped people.

The Office for Handicapped Individuals organized an Interagency Committee which consists of representatives of all programs for the handicapped. Its functions are to provide a means of communication, information exchange and program development for agency staff concerned with Federal programs for handicapped individuals.

As the Office for Handicapped Individuals assumed its responsibilities to embrace the cause of all handicapped people, the President's Committee on Mental Retardation provided leadership and expertise in behalf of mentally retarded individuals. The Office for Handicapped Individuals continues to cooperate with the President's Committee on Mental Retardation in matters involving the field of mental retardation.

The Office for Handicapped Individuals maintains a distribution list of over 14,500 names of persons and organizations which receive publications distributed by this Office and agency publications in the area of mental retardation and other disabilities. OHI has also represented the Department at national meetings of the American Association on Mental Deficiency, the National Association for Retarded Citizens, the Council for Exceptional Children, United Cerebral Palsy Association, and the Association for Children with Learning Disabilities. Publications and information were provided by Office staff to delegates during these meetings.

SUMMARY OF MENTAL RETARDATION ACTIVITIES

The mental retardation activities of the Department have been arranged according to the following categories: preventive services, basic and supportive services, training of personnel, research, construction, and income maintenance.

Preventive Services

Most States have enacted laws related to phenylketonuria (PKU) and make screening for this disorder mandatory. Throughout the country approximately 90 percent of the total registered live births are being screened.

Basic and Supportive Services

Basic and supportive services are defined as those services rendered to or for persons who are mentally retarded.

State health departments and crippled children's agencies use funds administered by the Maternal and Child Health Services for programs designed to: increase the health and welfare services available to the retarded, enlarge existing mental retardation clinics by adding clinic staff, increase the number of clinics, extend screening programs, provide treatment services for physically handicapped retarded youngsters, increase inservice training opportunities, and provide other care services for the mentally retarded.

The mentally retarded receive a variety of services through the vocational rehabilitation program supported by the Rehabilitation Services Administration: medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement and follow-up to insure successful rehabilitation.

The Health Services Administration, in conjunction with the Developmental Disabilities Office, Office of Human Development, supports projects for the retarded which have service components of well-integrated comprehensive health and mental health programs.

The Developmental Disabilities Office supports two programs directed at improving the quality of State institutional care and treatment for the mentally retarded. These programs are the Hospital Improvement and Hospital Inservice Training Programs.

The Developmentally Disabled Assistance and Bill of Rights Act, P.L. 94-103 enacted in 1975, amends P.L. 88-164, the Mental Retardation Act of 1963 and P.L. 91-517, the Developmental Disabilities Act of 1970. P.L. 94-103 authorizes appropriations for formula grants to States, grants for special projects and grants to university-affiliated facilities.

With the enactment of the Elementary and Secondary Education Act of 1965 (P.L. 89-10) and its subsequent amendments has come a number of new programs and services for the mentally retarded. The mentally retarded have especially benefitted from the provisions of Title VI of the aforementioned act, which provides opportunities for local school districts to develop new and creative programs for all handicapped children. The amendments of 1969 (P.L. 91-230), signed into law April 13, 1970, consolidated all legislation relating to education of handicapped children in Title VI. The Bureau of Education for the Handicapped in the Office of Education administers Title VI, which is now referred to as "The Education of the Handicapped Act." The passage of P.L. 94-142, "The Education of All Handicapped Children Act," mandates that the Federal government administer all programs under the requirement that the States set in motion plans and procedures to provide a free appropriate education to all handicapped children by 1978.

Training of Personnel

Training programs form an integral part of most of the mental retardation programs of the Department. These programs include support of professional preparation in the following areas: research training in the basic and clinical biological, medical and behavioral sciences; training of professional personnel for the provision of health, social and rehabilitative services for the mentally retarded; inservice training of workers in institutions for the mentally retarded; teachers and other education personnel related to the education of mentally retarded children; and training of personnel in physical education and recreation for the mentally retarded and other handicapped children.

Research

The National Institute of Child Health and Human Development in the National Institutes of Health will support mental retardation research and research training grants to an estimated amount of over $22 million in Fiscal Year 1976. The National Institute of Neurological and Communicative Disorders and Stroke, the National Institute of Arthritis and Metabolic Diseases, among other Institutes of the National Institutes of Health, also contribute to mental retardation research. These contributions directly or indirectly extend the efforts of the Mental Retardation Branch of the National Institute of Child Health and Human Development.

The Division of Research in the Bureau of Education for the Handicapped in the Office of Education now supports six Research and Development Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. of handicapped children. Through the combined efforts of Research and Development Centers and programmatic research, definite improvement in instructional procedures may well be realized within the next several years. New systems of dissemination are being built upon the foundations already developed by the Instructional Media Centers and a system of Regional Resource Centers currently are being developed. As more funds for research become available, engineering technology will more and more become a part of research supported by this Division. This development has been made possible by the amendment permitting the use of contracts as well as grants for research and development activities. Engineering technology, programmed instruction, and the "systems approach" to education will occupy a major place in the Division's activities in the years to come.

The Rehabilitation Research Branch Program of the Division of Research and Demonstrations of the Office of Human Development supports a substantial program of research on problems of rehabilitation of the mentally retarded. Areas covered include evaluation of aptitudes and abilities, analysis of jobs which the retarded can perform, opening of new occupational areas for the retarded, improvement of counseling techniques, development of new methods of training and job adjustment and evaluation of facilities and programs to assist the transition of the retarded person from the institution to community participation. Current programs of research and demonstration are increasingly concerned with new approaches to retardation in ghetto areas. Emphasis is placed on the coordination and focusing of all relevant community agencies on the problems of the retarded. The Research and Training Centers Division continues to sponsor three Mental Retardation Research and Training Centers. They are continuing to seek out the cause of mental retardation, to assess the potential for education and rehabilitation, to develop training and remedial programs, to ascertain their actual learning and socialization difficulties, and to develop methods to more adequately motivate the retarded for work.

Research grants administered by the Maternal and Child Health Service support projects directed toward the evaluation of programs and improving the development, management and effectiveness of maternal and child health and crippled children's services. Some examples of support include studies of the epidemiology of mental retardation in a rural county, sensory integrative processes and learning disorders, children with congenital rubella, perinatal casualty reports, galactosemia screening, and sensory motor activity in the neurologically handicapped child.

Construction

The university-affiliated facility construction program is administered by the Developmental Disabilities Office, Office of Human Development.

This construction program is authorized under P.L. 91-517, the Developmental Disabilities Services and Construction Act of 1970, which supplants in part and expands the old mental retardation law of 1963 to allow for grants to States for planning, construction, administration, and services for the mentally retarded, cerebral palsied, epileptic, and other neurologically disabled individuals. University-affiliated grants are made also to cover the costs of administration and operation of facilities and for the training of physicians and other professional personnel vitally needed to work with the mentally retarded.

Continuing progress is being made in developing projects for the construction of community facilities for the mentally retarded in widely scattered areas throughout the country. Facilities constructed under this legislation are designed topprovide diagnosis, treatment, education, training or care for the mentally retarded, including sheltered workshops.

Income Maintenance

The Social Security Administration administers a program which contributes to the maintenance of the mentally retarded through the payment of monthly benefits to eligible individuals. Effective in January 1974, the Social Security Administration added a new program, Supplemental Security Income (SSI), to provide payments to qualified aged, disabled and blind persons, including the mentally retarded. Under Title XVI, an estimated 310,000 retarded individuals who are not entitled to Title II benefits were receiving payments under the SSI program by the end of Fiscal Year 1975.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Obligations for Mental Retardation Activities

Fiscal Years 1975-1977
(Thousands of Dollars)

	1975	1976 Budget Estimate	1977 Budget Estimate
OFFICE OF EDUCATION			
Services			
Title I, ESEA, Educationally Deprived Children	$ 55,000	$ 58,000	$ 58,000
Title II, Library Resources	1,500	1,500 1/	1,500 1/
Title IV, Supplementary Centers	5,800	2,900 1/	---
Education for the Handicapped Act, Part B	15,000	15,000	15,000
Education for the Handicapped Act, Part C, Section 623	1,000	1,000	1,000
Education for the Handicapped Act, Part F	3,000	3,000	3,000
Vocational Education Act, Part B	20,000	2/	2/
Total, Services	$101,300	$ 81,400	$ 78,500
Training			
Education for the Handicapped Act, Part D	$ 6,100	$ 6,100	$ 6,100
Education Professions Development Act	---	---	---
Total, Training	$ 6,100	$ 6,100	$ 6,100
Research			
Education for the Handicapped Act, Part E	$ 2,707	$ 3,000	$ 3,000
Total, Research	$ 2,707	$ 3,000	$ 3,000
Other			
Library Services and Construction Act	$ 75	$ 75	$ ---
Total, Other	$ 75	$ 75	$ ---
TOTAL, OFFICE OF EDUCATION	$110,182	$ 90,575	$ 87,600

1/ These programs are being consolidated in fiscal year 1976 into a consolidated education grants program, which specifies that 50% of total funds must be used for activities funded in the previous year. In fiscal year 1977, total grant consolidation will be achieved.

2/ New legislation will be proposed for the programs involved. No estimates can be included for those activities.

	1975	1976 Budget Estimate	1977 Budget Estimate
PUBLIC HEALTH SERVICE			
Services			
Preventive health services Disease Control (P.L. 91-695 & 93-151)	$ 11,865	$ 5,959	$ 5,959
Total, Services	$ 11,865	$ 5,959	$ 5,959

	1975	1976 Budget Estimate	1977 Budget Estimate
PUBLIC HEALTH SERVICE (CONTINUED)			
Training			
National Institutes of Health National Institute of Child Health and Human Development	$ 1,535	$ 1,568	$ 1,306
Alcohol, drug abuse, and mental health Mental health (Section 303, PHS Act)	449	394	146
Total, Training	$ 1,984	$ 1,962	$ 1,452
Research			
National Institutes of Health National Institute of Child Health and Human Development	$ 20,499	$ 22,025	$ 22,058
Alcohol, drug abuse, and mental health Mental health (Section 301, PHS Act)	1,517	1,600	1,532
Total, Research	$ 22,016	$ 23,625	$ 23,590
Other			
Health resources Health Care Facilities (Title VI, PHS Act)	$ ---	$ 200	$ 200
Total, Other	$ ---	$ 200	$ 200
TOTAL, PUBLIC HEALTH SERVICE	$ 35,865	$ 31,746	$ 31,201
SOCIAL SECURITY ADMINISTRATION			
Income Maintenance			
Estimated Benefit Payments from RSI-DI Trust Funds	$343,440	$397,440	$471,600
Trust Fund Obligation Incurred to Adjudicate Claims of Beneficiaries	5,152	5,962	7,074
General Fund Payments for Supplementary Security Income 1/	372,048	444,528	535,680
General Fund Obligations Incurred to Adjudicate Claims for Supplementary Security Income . .	31,661	37,118	40,980
Total, Income Maintenance	$752,301	$885,048	$1,055,334

1/ Includes federal contributions toward State supplementation (hold harmless).

	1975	1976 Budget Estimate	1977 Budget Estimate
Health Insurance			
Estimated Payments from HI Trust Fund	$ 18,760	$ 24,660	$ 33,140
Estimated Payments from SMI Trust Fund	8,600	13,060	18,040
Trust Fund Obligations Incurred to Process Health Insurance and Supplementary Medical Insurance Claims	1,259	1,558	1,827
Total, Health Insurance	$ 28,619	$ 39,278	$ 53,007
TOTAL, SOCIAL SECURITY ADMINISTRATION	$780,920	$924,326	$1,108,341

	1975	1976 Budget Estimate	1977 Budget Estimate
SOCIAL AND REHABILITATION SERVICE			
Services			
Social Services, SS Act	$ 249,247	$ 295,800	$ 304,800
Medical Assistance, Title XIX, SS Act . . .	210,000	245,000	280,000
Total, Services	$ 459,247	$ 540,800	$ 584,800
Income Maintenance			
Maintenance Assistance, Title XVI, SS Act 1/.	$ 255	$ 274	$ 293
Total, Income Maintenance	$ 255	$ 274	$ 293
TOTAL, SOCIAL AND REHABILITATION SERVICE	$ 459,502	$ 541,074	$ 585,093

1/ Guam, Puerto Rico, and Virgin Islands only.

OFFICE OF HUMAN DEVELOPMENT

Developmental Disabilities Office 1/

	1975	1976 Budget Estimate	1977 Budget Estimate
Other			
State Grants (P.L. 94-103)	$ 28,176	$ 30,058	$ 33,058
Special Projects (P.L. 94-103)	21,199	19,317	16,317
University Affiliated Facilities (P.L. 94-103)	4,250	4,250	4,250
Total, Other	$ 53,625	$ 53,625	$ 53,625

1/ Funds indicated are the appropriation amounts for the three years. No data is available as to specific categories of developmental disabilities.

Rehabilitation Services Administration:

	1975	1976 Budget Estimate	1977 Budget Estimate
Services			
Rehabilitation Services			
Grants to States, VI Act, Sec. 110 . . .	$ 87,040	$ 90,440	$ 97,920
Innovation Grants, VR Act, Sec. 120 . . .	---	---	---
Expansion Grants, VR Act, Sec. 120 . . .	---	---	---
Facility Improvemement Grants, VR Act, Sec. 302(b)(c)	2,139	1,932	2,400
Total, Services	$ 89,179	$ 92,372	$ 100,320
Research			
Research and Demonstrations, VR Act, Sec. 202(a)	$ ---	$ ---	$ ---
Research and Training Centers, VR Act, Sec. 202(b)	550	669	---
Rehabilitation Activities Overseas (Special Foreign Currency Program)	125	100	100
Total, Research	$ 675	$ 769	$ 100

	1975	1976 Budget Estimate	1977 Budget Estimate
OFFICE OF THE SECRETARY (CONTD.)			
Rehabilitation Services Administration (Contd.):			
Training			
Rehabilitation Training, VR Act, Sec. 201(a)(2) and 203	$ 70	$ 70	$ 70
Total, Training	$ 70	$ 70	$ 70
Total, Rehabilitation Services Administration	$ 89,924	$ 93,211	$ 100,490
Office of Child Development:			
Services			
Head Start 1/	$ ---	$ ---	$ ---
Office for Handicapped Individuals 2/	$ ---	$ ---	$ ---
President's Committee on Mental Retardation	$ 726	$ 698	$ 768
TOTAL, OFFICE OF HUMAN DEVELOPMENT	$144,275	$147,534	$ 154,858

1/ Dollar estimate of Head Start and Child Welfare amount not available. Mentally retarded children are served in an integrated setting and funds are not specifically budgeted for mentally retarded children.

2/ Mental retardation figures not shown--OHI serves all handicapped individuals.

	1975	1976 Budget Estimate	1977 Budget Estimate
Total, Grants and Services	$ 778,188	$ 849,933	$ 911,491
Total, Income Maintenance	752,556	885,322	1,055,627
GRAND TOTAL, ALL FUNDS	$1,530,744	$1,735,255	$1,967,118

OFFICE OF EDUCATION

Report on Mental Retardation

(FY 1977)

Programs dealing with handicapped children in the Office of Education have been placed under the administrative direction of the Bureau of Education for the Handicapped. This is consistent with the efforts of the Office of Education to provide maximum educational programming for all children. The Bureau of Education for the Handicapped (BEH) is responsible for supervising and implementing current and new legislative authorities to provide funds for projects and programs relating to the education and training of and research on handicapped children and youth. These children include those who are mentally retarded as well as those who are hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired and require special education.

The overarching goal for Federal efforts in the area of education for the handicapped is to equalize educational opportunities for handicapped children. Only a bit more than 55 percent of the Nation's more than eight million school-aged handicapped children receive needed special education services.

The main issues surrounding the Federal role in education for the handicapped are:

1. How can the limited available Federal resources be used in a catalytic and stimulative manner to bring quality educational services to the greatest proportion possible of the unserved 45 percent of the target group?
2. What is the best use of Federal resources in preventing identifiable handicaps from becoming serious disabilities in school and adult life?
3. What educational techniques and methods can be developed, introduced and adopted to insure handicapped children job skills to enter adulthood with a high probability of participation in society in a meaningful manner?

Six objectives have been adopted for the Federal programs for education of the handicapped:

I. National Commitment

To insure that every handicapped child is receiving an appropriately designed education by 1978 (75% by 1977).

II. Increased Services

To assist the States in providing the appropriate educational services to 75% of the handicapped by 1977.

III. Career Education

To assure that by the year 1977, every handicapped child who leaves school has had career educational training that is relevant to the job market, meaningful to his career aspirations, and capable of bringing him up to his fullest potential.

IV. Manpower Development

To assure that all handicapped children served in the schools (75% by 1977) have a trained teacher competent in the skills required to aid the child in reaching his full potential.

V. Early Childhood Education

To secure the enrollment of 750,000 (75%) preschool aged handicapped children in Federal, State, and local educational and day care programs.

VI. Severely Handicapped

To encourage additional educational programming for severely handicapped children to enable them to become as independent as possible, including reducing their requirements for institutional care, and providing opportunities for self-development.

In order to efficiently implement the program and carry out the Federal mandate, the Bureau is administratively organized into four major divisions under the Office of the Deputy Commissioner. Each of the major Divisions -- Personnel Preparation, Assistance to States, Media Services and Innovation and Development -- functions as an integral element in the total Bureau program for handicapped children. The following pages describe the functioning of each division as it relates specifically to mentally retarded children.

Services

Division of Assistance to States

Under this Division, there are two branches. One administers the Aid to States programs and the second operates the severely handicapped programs, which includes the Deaf-Blind program.

Aid to States Branch Programs

A. Branch Purpose

The Aid to States Branch is responsible for administering and monitoring programs of assistance and also providing technical and developmental assistance to States in the design, development, implementation and review of State plans for the education of the handicapped. The Branch also serves as a clearinghouse of information concerning novel and/or effective approaches to special education in other States.

B. Historical Development

The purpose of Title VI, Part B, Education of the Handicapped Amendments of 1974, P.L. 93-380 was to provide funds to the States for the initiation, expansion and improvement of special education and related services for handicapped children at the preschool, elementary and secondary school levels; and may be used for the early identification and assessment of handicapping conditions in children under three years of age. Beginning in FY 1975, the State plan must include a goal of providing full educational opportunities to all handicapped children and provide for a procedure to assure the accomplishment of this goal, with priority for expenditure of funds going to serve children who are not receiving an education. The State plan must also provide for procedural safeguards concerning the identification, evaluation and educational placement of the children. With the passage of P.L. 94-142, "The Education for All Handicapped Children Act", the focus of this program changes from being primarily a catalytic or technical assistance effort to one of stringent implementation. The new law mandates that the Federal government administer all of these programs under the requirement that the States set in motion plans and procedures to provide a free appropriate education to all handicapped children by 1978. The responsibilities of the Federal government to enforce this law requires that the compliance of the States and local agencies must be monitored to determine that the States adapt extensive child identification, due process, confidentiality, least restrictive placement and individual child planning procedures in support of their timetable to provide a free appropriate education for every handicapped child.

C. Impact on Mentally Retarded

During fiscal year 1973, about $37.5 million was obligated for the Part B program. Of this amount about $12 million was expended in the area of mental retardation, providing direct services to 64,000 mentally retarded children. In 1974 the Part B appropriation increased to $47.5 million; $15 million of which provided direct services to 80,000 mentally retarded children. During 1975 and 1976, we are estimating that we shall be serving the same numbers of mentally retarded children.

The purpose of the P.L. 89-313 Amendment to Title I of the Elementary and Secondary Education Act is to provide assistance to the States for the education of handicapped children in State-operated and State-supported schools. A new provision, beginning in fiscal year 1975, requires that if a child is transferred from a State-operated or supported school to one operated or supported by a local school system that the P.L. 89-313 funds follow him there.

During recent years, as local facilities for the handicapped have increased, State schools have found the composition of their resident populations changing from the mildly handicapped to large percentages of children who are severely mentally retarded, and those who have serious handicaps in addition to mental retardation.

Model and pilot programs for these types of children have been conducted under P.L. 89-313 in many States.

These funds have enabled institutions and agencies to develop programs for children who have not previously been considered capable of responding to educational or rehabilitative services. The results in many instances have been encouraging and special educators and staff in residential institutions and day classes have raised their levels of expectations for such children. While this program originally had a relatively limited funding, significant results have been realized, especially in terms of planning for comprehensive services.

During fiscal year 1973, of $75.9 million expended, about $46.9 million was in the area of mental retardation, serving about 98,760 children. During fiscal year 1974 about $85.8 million was appropriated for this program. Of this amount, about $52.5 million went to mental retardation, serving about 103,000 mentally retarded children. In fiscal year 1975 $87.8 million was appropriated for this program to supplement the special educational services of approximately 179,000 handicapped children with $54,828,432 being used for 111,600 mentally retarded children. During fiscal year 1976, almost $96 million was allocated for this program to serve 188,078 handicapped children with 18,030 of such children being served in local educational agencies. Of the amount allocated for fiscal year 1976, $57,633,060 was used to serve 113,000 mentally retarded children.

In fiscal year 1977, we estimate that we will be serving 115,000 mentally retarded children in institutional programs and in programs operated and supported by local educational agencies.

Special Services Branch - Programs for the Severely Handicapped

A. Purpose

The Special Services Branch of the Division of Assistance to States monitors two special programs directing attention to severely handicapped children and youth. "Telecommunications for Severely Handicapped Children and Youth Who are Homebound," was designed to explore the effectiveness of modern telecommunications technology in the provision of educational/training services to those severely handicapped children and youth who are homebound due to restricted mobility or other aspects of social performance of physical involvement. Programs for Severely Handicapped Children and Youth provides for the funding of projects which would provide in conjunction with relevant public and private agencies and organizations within a State, (a) a plan for comprehensive services designed to meet identified, developmental needs of severely handicapped children and youth; (b) a model, demonstration program providing direct educational and/or training services for these children and youth which can ultimately be replicated State-wide and throughout the Nation; and (c) a dissemination strategy whereby information about exemplary program activities or elements will be made widely known to both professional and nonprofessional personnel working with or interested in the education/training of severely handicapped children and youth.

B. Assessment Needs

It is estimated that nearly one million severely handicapped children and youth are totally excluded from the educational system of our Nation. At least 300,000 others are not receiving adequate services.

The principal problems delimiting the delivery of effective educational/training services to severely handicapped children and youth, in those areas where such services are mandated or supported, include: (1) extensive deficiencies in personnel with expertise and experience; (2) lack of adequate, functional facilities; (3) general void of appropriate curricula, methodologies, and education/training programs; (4) scarcity of specialized materials and equipment; (5) limited child and youth identification; diagnostic, prescriptive and placement services; and (6) a general apathy or lack of concern for the needs of such persons, as well as the near nonexistence of advocate groups organized and functioning on their behalf.

The extreme shortage of adequate facilities, staff, and programs, has in many instances limited placement options for severely handicapped children and youth to already overpopulated institutions where, with a lack of funds, facilities, and staff, it has been impossible to provide little more than custodial care. Under more fortunate circumstances there may be more appropriate programs as institutions, and a variety of education/training service capabilities in home communities through mental health clinics, group home, halfway houses, and interim care placement centers. The States of Washington and New York are among those implementing some of these techniques. The "Rosenberg Report", a study in New York State in 1969, found that almost one-third of the retarded children and adults institutionalized by the State could be placed in the community if there were appropriate mental health and day-school facilities for them. At the present time, adequate facilities for such placements are very limited.

Among the most isolated of all severely handicapped children are those who reside in the Nation's "training schools for the retarded and mental hospitals for the emotionally disturbed." Many of these institutions are located far away from any developed community; often those in larger cities are in relatively isolated or inconvenient locations. Children in these institutions rarely leave the grounds of the facility and are almost never given the opportunity to participate in the educational programs of the local school district.

Despite programs administered under legislation such as P.L. 89-313, amendment to Title I, ESEA, which helps to serve nearly 175,000 children in State-operated and State-supported educational programs, tens of thousands of children are left on their own to pass their days without constructive educational programs or social therapy. Such critical personnel shortages exist, that often when services are provided, these services constitute little more than routine custodial care.

The failure to educate or train is still commonplace despite mandatory education laws and United States District Court statements. Pennsylvania Association for Retarded Children et al v. Commonwealth of Pennsylvania et al states that every retarded child is capable of receiving some form of education and that the Commonwealth must provide a free public education in accordance with every child's abilities.

C. Current Activities

The special Services Branch funded for continuation ten (10) programs and five (5) telecommunication activities for severely handicapped in fiscal year 1975. Seven new programs totaling $795,573, were funded, each directing attention to specific areas of the severely handicapped such as auditorial, visual, and orthopedic impairment, severely emotional disturbance and severely/profoundly retarded. The seventeen programs, totaling $2,826.00, will serve as model demonstration programs to be replicated throughout the States. The five telecommunication efforts, totaling $1,328,779, deal with Telecommunications for Severely Handicapped Children and Youth Who Are Homebound. Telecommunications can be a link between severely handicapped children and the improvement of their social skills and enrichment of their general life situation.

D. Historical Overview and Future Goals

The Bureau of Education for the Handicapped has been particularly interested in launching a concerted effort on behalf of the severely handicapped because of the demand and apparent need for services to this population, the difficult financial position of local and state governments, and the extent of successful activities conducted in the programs for deaf-blind children, funded by the Bureau over the past several years.

Through the BEH objective and activities addressed to the needs of severely handicapped, we will undertake cooperative planning with related Federal agencies and with State departments of special education to target resources at this population. There will be a program of technical assistance to State education agencies to improve both their management and planning techniques so as to make maximum use of all Federal resources that can be dedicated to the needs of the severely handicapped.

The specific strategy proposed for implementation by BEH during fiscal year 1976 as a sustained thrust toward meeting the educational/training needs of severely handicapped children and youth is: to develop and refine a national compact berween BEH and selected States on the education and training for the severely handicapped. A tentative plan for such an agreement has been drafted to incorporate the major service delivery problems that will have to be considered, resolved and funded from State and Federal resources. The current intent is to discuss this plan in whole and in the broad spectrum encompassed by its several parts, with selected States. The objective of this year's activity is to engage in a dialog with these States to determine the feasibility and possible deficiencies of the task required to launch the implementation stage of such a national plan. In furtherance of the intent of this year's activity, it is visualized that we would pursue this effort along two lines: (a) a technical assistance colloquy with the several States to explore various areas of mutual concern, and (b) the development of bench-mark data to be used tentatively in a preliminary assessment of the scope, quality and breadth of the plan.

E. Impact on the Mentally Retarded

The following statistical analysis denotes the current participants in "Programs and Telecommunications for Severely Handicapped Children and Youth." As it reflects in the data presented, 56% of the children served were considered to be severely mentally retarded and 28% were considered to be Multi-handicapped. In terms of money expended the percent reflects approximately: $1,749,903 to be expended on behalf of severely mentally retarded and $1,065,158 on behalf of the multi-handicapped.

PROJECTS BY STATE	Severe Mental Retardation	Severe Emotional Disturbance	Multi-Handicapped	TOTAL
Alabama	24	23	4	68
California	4	77	9	90
Indiana		15	15	30
Kansas	15	11	4	30
Michigan			14	14
New Mexico	51	8	45	104
Oregon	4	10	11	25
Rhode Is.			55	55
Washington	136	31	34	201
Wisconsin	72		113	185
Tele/C Indiana	33	7	10	50
Kentucky	18			18
N Y City		30		30
N Y State			80	80
Utah	59		64	123
TOTAL	416	218	475	1,103

Centers and Services for Deaf-Blind Children

A. Program Purpose

The purpose of this program is to "provide through a limited number of model centers for deaf-blind children, a program designed to develop and bring to bear upon such children, beginning as early as feasible in life, those specialized, intensive professional and allied services, methods, and aids that are found to be most effective to enable them to achieve their full potential for communication with and adjustment to, the world around them, for useful and meaningful participation in society and for self-fulfillment."

These centers will develop and provide services to children who are deaf-blind and have been deprived of their major avenues of learning and contact with the every-day experiences of life.

B. Historical Background, Legislation and Funding

Public Law 90-247 was signed on January 2, 1968. This legislation was in response to the rubella epidemic (German Measles) that swept the nation and left many children with auditory and visual impairments, as well as other handicapping conditions including mental retardation. Approximately 5064 children were left deaf and blind. There were no programs in existence for such children at that time. In 1969, the first eight regional deaf-blind centers were started. In 1975, there was a total of 10 Regional Deaf-Blind Centers serving deaf-blind children in all 50 States and U.S. Territories.

Total funding approved for Centers and Services for Deaf-Blind Children is as follows:

1969	$1,000,000.00
1970	2,000,000.00
1971	4,500,000.00
1972	7,500,000.00
1973	10,000,000.00
1974	14,055,000.00
1975	12,000,000.00
1976	16,000,000.00

4516 deaf-blind children are in various types of educational programs located in public and private institutions and state hospitals for the mentally retarded. Some of the types of services offered by the Deaf-Blind Program are as follows:

1. Full and part-time education services (both residential and day.)
2. Diagnosis and Evaluation
3. Parent Counseling
4. In-Service Training

5. Short-term program (summer school, respite care)

6. Pre-vocational programs

C. Impact on Mental Retardation

Children born with rubella have many handicapping conditions; many of the children are mentally retarded or show evidence of mental retardation. 800 of our deaf-blind population are receiving services in state hospitals for the retarded. Many more of these children who are deaf-blind and mentally retarded are in programs at public and private institutions. Between 50-85% of children in deaf-blind programs have also been diagnosed as having some degree of mental retardation.

Division of Media Services

Under the Division of Media Services there are three major activities: Media Services and Captioned Films, Recruitment and Information, and Regional Resource Centers.

Recruitment and Information

The recruitment and information program comes directly under the purview of the Deputy Commissioner.

A. Program Purpose

(1) to link parents of handicapped children and youth with needed and appropriate educational and related support services through information and referral to state and local resources; by reaching through mass media, parents of handicapped children who have failed to find appropriate services for these children, to respond to public inquiries generated by media and by assisting local groups in their efforts to meet information and referral needs of parents; (2) to assist State and local planners in providing adequate and appropriate services to handicapped children by supplying valuable consumer feedback to the service delivery system; and (3) to encourage regular education teachers to pursue careers to become teachers of the handicapped.

B. Historical Development

The National Special Education Information Center is now almost six years old. In the past it has directed its greatest efforts to making direct responses to parents by answering telephone inquiries and responding to mail inquiries. It has advertised its services on radio and television and in newspapers. It has also sponsored talk shows by special educators on radio and television.

Currently it is continuing these major efforts, but expanding on them through surveys of existing services, support of local parent groups and provision of feedback to the State and local delivery systems.

C. Impact on Mental Retardation

The Center provides comprehensive information on needs, rights and services for handicapped children. It has answered a quarter of a million letters and more phone calls from concerned parents and provided information to hundreds of parent organizations, and to Federal, State, and local agencies, which have passed along the information to individual parents. While its efforts have not targeted on any individual handicapping condition, the Center has had a great impact on the provision of services to the mentally retarded.

Media Services and Captioned Films

A. Program Purpose

This program, authorized under Part F of the EHA provides the handicapped learner with specific educational materials directed at his (her) educational needs. This purpose is being advanced through the operation of Centers for Educational Media and Materials for the Handicapped and a network of Area Learning Resource Centers which focus on the development and dissemination of materials and media for the education of the handicapped. Another major purpose is the captioning and distributing of motion picture films and other media to the deaf and hearing impaired population.

B. Historical Development

During 1974 and 1975 more than 4363 groups of hearing impaired persons, representing an audience of 3.0 million people, were reached through the Media Services and Captioned Film program. Of these 1541 were schools or classes for the deaf. The total audience for theatrical films numbered over 1.6 million with a monthly average of 4,000 showings.

The program circulated more than 700 different captioned educational films through its 60 film depositories.

In 1976 the number of groups of hearing impaired persons reached will exceed 4,800 (1,600 schools and classes for the deaf). The captioned theatrical and cultural films will reach a total audience of 1.8 million persons with a monthly average of 5,000 showings.

800 captioned educational film titles will reach an audience of 1.7 million hearing impaired children, with classroom showings averaging over 4,000 per month.

Support of the National Theatre for the Deaf is continuing, and a daily captioned evening news broadcast over the national PBS network was continued. Experiments to develop an electronic coding system to provide captioned television programming to a potential audience of more than 13 million hearing impaired Americans are now in the testing stage and a National system is expected to be operational in two years.

The National Center on Educational Media and Materials for the Handicapped is conducting a needs assessment of specific requirements and standards for media and materials for handicapped children. The network of 13 Area Learning Resource Centers and 4 special category centers is providing a national delivery system of educational media to handicapped children.

C. Impact on Mentally Retarded

The National Center on Educational Media and Materials for the Handicapped and one of the specialty centers associated with the National Center are actively working with the States in the development of media and materials for the mentally retarded and other handicapped learners.

Regional Resource Centers (RRC's)

A. Program Purpose

The Regional Resource Centers (RRC's) were established under Part C of EHA. Presently, there are thirteen (13) RRC's serving their respective regions by supporting assistance to States in developing an intrastate capacity in regard to the following educational services and to provide said services to the states' service-clients within service rules which are clearly reinforcing of local and state capacity: appraisal of handicapped children, diagnosis of learning disorders and prescription of educational programs of handicapped children. The RRC's are concentrating their efforts on development of resources and services for the unserved, underserved and difficult to serve segments of the handicapped population, i.e., poor inner city and rural populations including a high percentage of the ethnic minorities.

B. Historical Development

In fiscal year 1973, in conjunction with State and local education agencies, the program provided specific diagnostic, evaluative, prescriptive remedial or supportive services. Program strategies were designed to achieve the catalytic effect of influencing practices to enable more children to be placed in regular school programs.

In 1974, the major concern of the centers was to improve the effectiveness of on-going practices and of developing and implementing the use of new techniques where none existed. The major objective was to assure that all geographical areas covered by RRC programs had access to services directly or through cooperative efforts. Coordination of planning activities with the National Media and Materials Center is to bring about a dynamic, interrelated resource system.

In 1974, approximately 40,000 handicapped children received comprehensive services from six Regional Resource Centers. Approximately 200 State education agencies and 6,000 local education agency personnel received training through workshops, special study institutes, and technical assistance activities. Also, 2,000 severely and multiple handicapped children received services in addition to the 40,000 children mentioned above.

In 1975, considerable emphasis is being placed by the 13 RRC's serving their 57 client states on developing the SEA's "Master Plan" for special education services to handicapped children as the plan relates to appraisal and programming.

C. Impact on the Mentally Retarded

By the end of 1974, the RRCs had provided services to approximately 80,000 children, of which 30,000 were mentally retarded. By the end of 1975, the RRC's should have provided services to 104,000 children of which 39,000 are mentally retarded. In addition, support will be provided to 400 state educational service agencies and 10,000 local education agencies who provide services to the Nation's handicapped children.

ESEA Title II Projects for the Mentally Retarded

Title II of the Elementary and Secondary Education Act, administered by the Office of Libraries and Learning Resources in the Bureau of School Systems provides school library resources, textbooks, and other printed and published instructional materials for the use of children and teachers in public, private, and special State elementary and secondary schools. Children with all types of handicapping conditions and their teachers are eligible participants. A review of a sample of projects under ESEA Title II indicated that materials provided for their use with ESEA Title II funds have been mostly audiovisual materials, and picture and easy books. A larger number of projects for mentally retarded children were supported with instructional materials under ESEA Title II. Examples of such projects in two States are:

Pohukaina School, Oahu; Hawaii - A dynamic school librarian, with creative and innovative ability, has built this school library into a place of joy and rejuvenation for the children in this school--severely mentally and physically handicapped. Many of her little patrons are confined to wheelchairs, unable to manipulate of their own initiative, but able to get to the library because she has provided ramps and aisle space to accommodate them. Through her initiative an organization of airline stewardesses has "adopted" the children in this school, and provided much needed audiovisual equipment that many of the youngsters can use independently. Individual carrels (some made of large packing crates by the librarian) are set up with equipment plugged in and on the shelf above, the types of material for use in that piece of equipment. Audiovisual materials have been provided through ESEA Title II funds.

Martin Luther School, Beatrice, Nebraska - A very practical program is being carried out for the trainable and educable mentally retarded pupils enrolled in this private school. Development of perceptual skills is combined with attainment of defensive reading skills, emphasizing functional words of everyday life, reading of signs, directions, numbers, pictures, and other matter leading to social independence. Teachers use flash cards, posters, picture books, newspapers, filmstrips, recordings, worksheets, pamphlets, and games to heighten pupil interest. Constant reinforcement and practice are built into the program to increase motivation and retention of what is learned. ESEA Title II funds supplied many of the materials used.

Title IV of the Elementary and Secondary Education Act

As part of the comprehensive effort to demonstrate innovative approaches to solve the needs of handicapped children, Title IV of the Elementary and Secondary Education Act mandated that 15 percent of its Part C project funds(not including Title V funds) be set aside for special education programs for the handicapped.

Title IV projects, administered by the Bureau of School Systems, are not designed "to meet the needs of handicapped children" but rather to demonstrate the solutions to critical problems in American education as they relate to the handicapped. It is recognized that the needs of these children will be met when appropriate programs are designed and implemented but this should not be the major thrust of Title IV funds for the handicapped.

In many respects the intent of the legislation has been met. In other respects it has not. As more sophisticated procedures for identifying handicapped children are developed, as projects to serve these children are conceived, as the innovativeness and creativity of the project designs are improved, Title IV personnel, working jointly with special education personnel and other local, State and Federal agencies will be in a better position to meet the mandate of the legislation.

Vocational Education Act

Under the Vocational Education Amendments of 1968 which were funded in fiscal year 1970, a number of programs were developed by vocational education agencies in fiscal year 1970, a number of programs were developed by vocational educational education agencies in which 115,300 handicapped persons were enrolled. Although vocational education reports do not give data by category of handicapping conditions, deaf, blind, crippled, emotionally disturbed, and mentally retarded educable and trainable were all listed among the categories being served. Unvalidated information indicates that the largest single category is still the Mentally Retarded with more than half of the enrollments being so diagnosed.

	1974	1975 EST.	1976 EST.	1977 EST.
Total handicapped enrolled in Vocational education: (in thousands)	234	266	290	310
Secondary........................	182	196	210	220
Postsecondary.....................	31	40	45	50
Adult............................	21	30	35	40

A project entitled An Assessment of Vocational Education Programs for the Handicapped Under Part B of the Vocational Education Amendments of 1968 was performed by Olympus Research Corporation and the final report was submitted to the Office of Education, Planning, Budgeting, and Evaluation. This report indicates that in a representative sample of vocational education programs for the handicapped in 19 States, 84% of students diagnosed as handicapped were categorized as mentally handicapped: 66% were educable mentally retarded; 12% were trainable mentally retarded; 4% were learning disabled; 1% were emotionally disturbed, and 1% were educationally handicapped; 15% were physically handicapped and 1% were multi-handicapped.

Mentally retarded are being served in special classes in State schools, in local educational agencies, and in regular vocational education programs in vocational schools. In most programs the objective is to provide those services and program modifications which will assist the mentally retarded person to become employable at the highest level of which he/she is capable. We are finding that we have underestimated the potential of many and are modifying our approaches to provide more individually prescribed instruction and better assessment of potential through use of Vocational Rehabilitation/Vocational Assessment programs and through other assessment tools.

Inservice training of vocational education instructors to enable them to better serve the handicapped has been supported at the National level and is being offered in all States under State Department of Education, Vocational Education Division. Teacher Training Institutions for Vocational Education Leadership are becoming increasingly active in providing preservice and postgraduate education for vocational education instructors concerned with handicapped students.

In most local programs, any mentally retarded adults that are served are included in the regular groups. As the Adult Education Program is expanded to serve more adequately groups with special needs, mentally retarded adults will be provided specialized programs, with increased cooperation between the Adult Education Program and local programs and services designed to serve the mentally retarded.

Training

Division of Personnel Preparation

A. Purpose

The Division of Personnel Preparation of the Bureau of Education for the Handicapped initiates, maintains and improves programs for the preparation of professional leadership and teaching personnel so that the States can reach the goal of properly servicing handicapped children and youth by 1980. Divisional programs which are designed to respond to this goal are four-fold in their attack in that they must provide: (1) classroom supervisory, consultative, and administrative personnel for State and local special education programs; (2) personnel for higher education institutions responsible for preparing administrative and classroom personnel; (3) paraprofessionals for special education programs; and (4) training for regular educators to work with handicapped children.

B. History

In 1958, Public Law 85-926 was passed by Congress authorizing an appropriation of $1 million per year for the preparation of professional personnel in the education of the mentally retarded. This initial piece of legislation was directed at preparing college and university personnel to staff the then existing programs, and much needed new programs for preparing personnel to work with the handicapped in State and local school systems. Between academic years 1959-60 and 1963-64 692 graduate traineeships were granted to 484 individuals who became college and university professors while 208 others became State and local special education leadership personnel.

On October 31, 1963, P.L. 88-164 was signed into law. Section 301 of this Act amended P.L. 85-926 to: (1) expand the program to include not just the area of mental retardation, but also the areas of the visually handicapped, deaf, crippled and other health impaired, speech and hearing impaired, and the emotionally disturbed; (2) allow for the preparation of teachers and other specialists in addition to leadership personnel at the graduate level; (3) extension downward into the senior year undergraduate levels; and (4) increase the monies authorized for these purposes.

Public Law 85-926 was further amended with the passage of Public Law 89-105 and 90-170. These amendments expanded and extended the program through fiscal year 1970, authorizing appropriations at 29.5 million for fiscal year 1967; $34 million for fiscal year 1968; $37.5 million for fiscal year 1969; and $55 million for fiscal year 1970.

These appropriated funds have been used as stipends for students as well as to support colleges, universities, and States education agencies. Since P.L. 85-926 was passed in 1958, approximately 109,000 traineeships have been awarded to individuals preparing to work with mentally handicapped children. This included both short-term and full academic year awards.

State Education Agencies have received approximately 6,000,000 in recent years to provide short term training in their respective states. This money has been largely used to provide for inservice training of special educators.

Training Awards in the Area of Mental Retardation Fiscal Years 1960 through 1975.

Fiscal Year	Number of Traineeships	Number of Higher Education Institutions Participating	Number of State Education Agencies Participating	Total Amount Obligated
1960	177	16	23	$ 985,222
1961	164	18	41	993,433
1962	160	20	46	997,000
1963	163	19	48	996,433
1964	2,357	108	50	6,419,332
1965	2,506	153	50	6,569,815
1966	3,110	162	52	7,658,002
1967	3,816	177	53	8,891,072
1968	4,521	177	53	8,493,668
1969	6,366	193	53	9,382,084
1970	6,171	200	55	10,391,341
1971	4,909	207	55	8,955,355
1972	5,100	210	56	8,955,355
1973	4,830	215	56	8,476,181
1974	5,835	225	56	10,240,450
1975	2,050	225	55	6,100,000

This program has enabled a great number of colleges and universities to develop and/or expand their teacher training programs in mental retardation. A current analysis of the more than 300 institutions requesting funds in the area of mental retardation indicates that more than 170 of them have on their faculties former trainees of the program.

Under current awards policy, which gives more authority to universities to administer their own programs according to local needs and requirements it is difficult to report discrete number of teachers being trained for mental retardation. However, it is our best judgement from review of proposals received that the number of teachers being trained for mental retardation has not diminished. Although only 2050 students received direct financial assistance, there were over 25,000 students enrolled in training programs in the area of mental retardation and funds allocated have not been reduced. Emphasis is now being placed on training teachers to serve the more severely retarded child. Institutions are changing training programs to fit this demand.

C. Cooperative Activities

The Division of Personnel Preparation in an effort to utilize all resources in the provision of quality educational programs for all retarded children has entered into cooperative funding or working arrangements with other personnel training programs in the Office of Education and the Social and Rehabilitation Service. The following are three examples of the Division's cooperative efforts:

University Affiliated Facility Program

The Division of Personnel Preparation in cooperation with the Division of Developmental Disabilities, Rehabilitation Services Administration (SRS) provided support monies to special education components in university-affiliated facility programs for fiscal year 1975. The extent of the Division's support ranged from approximately $20,000 to $30,000 with a total expenditure of $396,000.

The Division supports a special educator on the university affiliated facility core faculty. The special educator is responsible for instructing medical students, psychologists, social workers, and other related medical personnel as well as students majoring in special education. He serves to effectively integrate special education concepts into the overall interdisciplinary training program of the university affiliated facility.

The institutions receiving support through this program for recent years were: Georgetown University; University of California at Los Angeles; Johns Hopkins University; Indiana University; University of Miami (Florida); Ohio State University; University of Cincinnati; University of Tennessee (Memphis); Children's Hospital (Harvard); University of Oregon; University of Alabama (Birmingham); Utah State University; University of Wisconsin; Georgia Retardation Center (Georgia Department of Public Health); University of Kansas; the University of Michigan; University of North Carolina.

D. Special Projects

The Special Projects program in the Division of Personnel Preparation, Bureau of Education for the Handicapped, is designed to provide an opportunity for conceptualizing and implementing on a trial basis, approaches to personnel preparation for the education of the handicapped children which are basically new or which are significant major modifications of existing personnel preparation programs. Special Projects are designed to encourage and facilitate innovative approaches to the solution of major training problems.

Currently there are approximately 40 operational Special Projects funded by the Division of Personnel Preparation. Approximately one-fourth of these projects are concerned with the preparation of personnel to educate retarded children. Most of these projects are primarily concerned with the most severely handicapped. During fiscal year 1975 approximately one-fourth of the 3.7 million dollars invested in these projects was specifically targeted for the mentally retarded.

E. Future Goals

The goals of the Division of Personnel Preparation are to:

1. Increase the number and quality of personnel for education of the handicapped with special attention to early childhood education, vocational education, the urban and rural poor, paraprofessionals and to train regular classroom teachers to teach the handicapped.

2. Increase the amount and quality of technical assistance to agencies and institutions training professional personnel.

3. With State departments of education and institutions of higher education effect cooperative planning for the training of personnel in special education.

4. Develop a systematic data collection program upon which to monitor current efforts and to base future efforts.

Research

A. Purpose

The Research Program of the Bureau of Education for the Handicapped promotes and supports research and related activities which show promise of leading to improvement in educational programs for handicapped children. Support is available for research, dissemination, demonstration, curriculum, and media activities.

B. History

This program, now administered by the Research Projects Branch, was initiated during fiscal year 1964 with appropriation of one million dollars authorized under Title III, Section 302 of Public Law 88-164. This authorization has been continued, through the ensuing years and the scope and flexibility of the program have been expanded. In April, 1970, the various acts of legislation that pertained to research were incorporated into P.L. 91-230, Education of the Handicapped Act. The latest Act, P.L. 93-380 provided for authorization through fiscal year 1977. An increasing proportion of research funds have been allocated to projects which impact more generally on the education of handicapped children. In general, such "non-categorical" projects have tended to equal or exceed the amount of activity directed specifically at the field of mental retardation, and may be assumed to have virtually as much an impact on programming in the field of mental retardation as do those projects which relate to problems specific to the mentally retarded.

C. Impact on the Problem of Mental Retardation

It is frequently difficult to assess the direct impact of research activities on educational programming since the lag between the discovery of new knowledge and consequent changes in educational practices obscures the relationship. However, a number of suggestions regarding program impact are available. As of the end of 1974, supported projects had resulted in the distribution of over 500 project reports relating to education of the mentally retarded through the ERIC system, and at least an equal number of publications in professional journals. In addition validated curriculum materials designed specifically for mentally retarded groups have been developed and are now available in the area of social learning, arithmetic, science, physical education, and self help skills. Special education instructional materials centers and regional resource centers for the handicapped which began as development/demonstration projects supported through the research program have now become institutionalized service operations providing services to the mentally retarded as well as other handicapped populations.

D. Current Activities

A number of research and research related activities relevant to the education of mentally retarded children are currently being supported by the Research Projects Branch. A major applied research program is involved in a series of studies relating to the effects of teacher behavior on pupils, and on ways of establishing more effective teacher behaviors. Another major program is investigating methods of optionally matching learning characteristics of retarded children with various teaching methods and environments. Development of additional specialized curriculum materials for the mentally retarded continues with particular emphasis on development of new materials for severely retarded children.

Additional efforts of a more general nature also have particularly important implications for the retarded. Among the most important projects currently being conducted is an investigation of reintegration of handicapped children into regular education programs. A second major effort involves a series of eleven demonstration projects involved in the investigation of techniques for integration of a wide variety of community services available to retarded and other handicapped children.

E. Future Goals

In order to stimulate more effective programming for handicapped children the research and development program is structured to link research and research related activities more directly to the support of special education services. Major areas of emphasis are:

1. Assessment of the effectiveness of special education curricula and procedures.

2. Development of new curricula, materials, and techniques.

3. Encouragement of the broadest possible diffusion, utilization, and implementation of effective procedures.

Of particular importance in the area of mental retardation are: continued attention to development of curriculum and materials, investigation of the effects of integrating retarded children, and increased attention to the problems of severely and profoundly retarded children. Across all these activities attention will be concentrated on problems of early education and career education for the retarded.

RESEARCH PROJECTS IN MENTAL RETARDATION

YEAR	NUMBER	AMOUNT
1964	9	$238,270
1965	14	520,905
1966	39	1,110,089
1967	32	1,084,429
1968	31	1,608,076
1969	29	2,184,921
1970	16	1,601,709
1971	10	4,413,863
1972	7	2,204,723
1973	10	3,020,347
1974	14	2,599,405
1975 estimate	27	2,706,927
1976 estimate	15	3,000,000

Other

Program funded by Title I, Library Services, of the Library Services and Construction Act (LSCA) benefit many mentally retarded children and adults whether they live in State of local residential facilities or in private homes. This program is administered by the Office of Libraries and Learning Resources in the Bureau of School Systems. Under this State administered matching program, libraries are established and improved in residential institutions operated or substantially supported by the State; specialized materials and services are provided to persons who, because of physical handicap, are unable to read or use conventional printed material; and public library services are extended and improved in areas where they are inadequate.

It is difficult to estimate the number of public library programs reaching the mentally retarded because they are often part of broader services such as Library Outreach Summer Reading Programs for Children, etc. There is growing evidence, however, that public libraries are developing collections and programs for mentally retarded persons who visit the library individually or in groups, and are taking services to those who do not come to the Library.

In 1975, sixty-five of the approximately 150 eligible State institutions for the mentally retarded received special LSCA, Title I grants for the improvement of library services to residents. In addition, all the eligible institutions benefited indirectly, at least, by the provision of services by State and public libraries through such activities as interlibrary loan, film circuits, talking books and training and consultative services.

One of the outstanding examples of special LSCA projects for the mentally retarded is:

Montana - The Montana State Library established a branch library within the Boulder River School and Hospital for mentally retarded persons. The School contributed the physical space and the utilities; the State Library uses LSCA funds to provide a full-time professional librarian and a collection of books, educational toys, games, and audio-visual materials selected for maximum developmental and recreational use by some 600 seriously retarded youngsters, as young as four years old. Moving from temporary quarters in the Schools basement, the Library opened in early 1973 and has been a source of pride and a scene of good happenings to all involved. To illustrate: a browsing section of the Library is used by 60 foster-grandparents to read to their "grandchildren", to introduce learning games, toys, and to enjoy their close and supportive relationship, compounding the impact of both Federal programs for the benefit of the retarded youngsters in Boulder.

PUBLIC HEALTH SERVICE

Center for Disease Control

Immunization

The rubella epidemic of 1964-65 resulted in an estimated 30,000 cases of congenital rubella syndrome, or severe birth defects, leaving 13,425 babies mentally retarded, deaf or blind. With the licensure of a live virus rubella vaccine in 1969, a major program was undertaken to vaccinate a sufficient number of children to prevent a future epidemic which, based on past epidemiologic data, was predicted for the early 1970's. Project grants were awarded to State and local health agencies to launch an intensive rubella immunization program. Within little more than 2 years, over 30 million doses of rubella vaccine had been administered in public immunization programs. This represents the largest number of immunizations ever administered that quickly after licensure of a vaccine. Over 67 million doses of rubella vaccine have now been distributed.

The predicted rubella epidemic has not occurred, and in fact reported cases of rubella declined steadily from 56,552 in 1970 to 11,917 in 1974. However, during 1975, 16,343 rubella cases were reported, representing an increase of 37 percent compared to 1974. An estimated 16 million children under the age of 14 remain unprotected against rubella.

Lead-Based Paint Poisoning Prevention

Hyperactivity, mental retardation and neurological damage have been attributed to the ingestion and absorption of lead. Approximately 6,000 children per year suffer some neurological damage from increased lead absorption.

The ubiquity of lead in the child's living environment, particularly under conditions of housing deterioration and flaking and peeling lead based paint, accounts for the increasing problem of lead absorption among urban children.

Project grants and technical assistance are provided by the Center for Disease Control for detection, treatment and hazard reduction activities in local communities throughout the United States which have demonstrated the existence of a lead poisoning problem.

During 1975, 77 community programs tested 440,650 children and identified 28,597 (an increase of 76% from 1974) with evidence of undue lead absorption. Medical and environmental services were provided to protect these children from the effects of overt lead poisoning.

PUBLIC HEALTH SERVICE

National Institutes of Health

National Institute of Child Health and Human Development

The National Institute of Child Health and Human Development (NICHD) supports research into the biological, behavioral and social processes which contribute to or influence the development of retarding disorders. Of primary concern are basic studies into the causes and means of preventing mental retardation. The Institute employs research grant support, creates and supports special research facilities and resources, disseminates scientific and public information, and provides contract support of research to accomplish its specified goals. This Institute's research programs and resources provide research knowledge and understanding applicable not only to the problem of mental retardation but to other closely related developmental disabilities as well.

Research into the causes, means of prevention, and methods of amelioration of mental retardation serves many of the research requirements of the developmental disabilities including cerebral palsy, epilepsy, autism and special learning disabilities. With the exception of special learning disabilities, mental retardation is frequently associated with the other developmental disabilities.

These conditions are a frequent consequence of reproductive casualty resulting from disorders of pregnancy, complications of birth, and maternal ill health. The Institute, because of its assigned responsibility for research in maternal and child health, has a major research concern for these disorders. All of the Institute's research programs make significant contributions concerning these issues.

Many of the research accomplishments supported by the NICHD have been achieved in the Institute's 12 Mental Retardation Research Centers. These interdisciplinary Centers, located throughout the country, are uniquely capable of investigating the complex problems of mental retardation and related developmental disabilities, training of future scientists, and applying research findings to service. The close working association of the Centers to the University-Affiliated Facilities (U-AF), (10 of the 12 Centers are directly related to the U-AFs administratively) which are concerned with the full array of developmental disabilities, further expands their research capabilities. Together, these Centers represent a major national resource for research aimed at finding the means of prevention and amelioration of mental retardation and related developmental disabilities.

Research and Prevention

Considerable research progress over a wide range of problem areas has been reported by NICHD-supported investigators over the past year. Some of these activities, reported below, indicate the nature of the Institute's research efforts.

Researchers at the Mental Retardation Research Center (MRRC), University of California at Los Angeles, have contributed substantially to the more precise definition of the enzyme deficiency responsible for galactosemia, an inherited metabolic disorder causing mental retardation, and even death, if untreated in early infancy.

These investigators have developed methods for the isolation of the pure enzyme from human red cells, and have prepared an antiserum to it in rabbits. Using this antiserum they have shown that a pure protein, immunologically identical with the normal transferase, can be isolated from the red cells of galactosemic patients.

These observations leave no doubt that galactosemia results from a structural gene mutation with a conservative replacement of an as yet unidentified amino acid near the active site of the enzyme. This would seem to be the first instance of the isolation of a catalytically inactive mutant "enzyme" from human sources. This work is significant in that it has opened up the study of all galactosemic abnormalities of which several variants exist.

Over a number of years, the University of Chicago Mental Retardation Research Center has been involved in studies aimed at determining the nature of the biochemical defects which lead to abnormal storage of certain sugar-containing large molecules. Storage of these materials results in distortion of tissue throughout the body including the brain with consequent crippling and mental retardation. During these investigations it was shown that cells obtained from afflicted patients may be cultured in the laboratory and utilized for study of the basic genetic defects in these diseases. This technique has now been widely adopted for the study of genetic diseases. Utilizing this technique the Chicago Center, together with other Centers, has been able to define the biochemical defect in a number of diseases (the mucopolysaccharidoses) which lead to severe mental retardation. During the past year the defects in two such diseases, Maroteaux-Lamy and Morquio's disease have been identified.

These studies have already resulted in important applications to the control of mental retardation. Included are methods of prenatal diagnosis and carrier detection. Studies on mucopolysaccharidoses have led to great interest in the possibility of treatment of storage diseases by enzyme replacement. At present, efforts are being made in many laboratories to devise methods of administration of purified enzymes.

Studies in the Chicago laboratories have defined the nature of the material stored in two additional diseases, a-fucosidosis and a-mannosidosis which result in the interference with the breakdown of a number of sugar-containing substances. Attempts are now underway to purify the involved enzymes, a-fucosidase and a-mannosidase so that such purified enzymes might be used for treatment.

Research in genetics and inborn errors of metabolism continues as a priority research area for the NICHD. Well over 60 mental retardation syndromes have been identified as having genetic orgin. It has been estimated that genetic defects are present in 5 percent of all live births; over one-third of all spontaneous abortions are associated with chromosomal defects; and about one-third of all admissions to hospital pediatric wards are for genetic reasons. In institutions for the mentally retarded today, about 5 percent of the patients have inborn errors of metabolism, over 10 percent have Down's syndrome, and 25 percent have central nervous system defects, many of which are inherited. Most of these genetically determined conditions are associated with mental retardation or defects which impair a child's ability to achieve his optimal development. Activity in this field will be encouraged in 1977 with emphasis given to moving genetic knowledge and developments into service. An automated system for chromosome analysis has been developed recently, under interagency agreement between the NICHD and the Jet Propulsion Laboratory (NASA), and involving the collaboration of computer scientist from JPL and cytogeneticists from the City of Hope National Medical Center in California. A computer-controlled microscope automatically scans microscopic slides or photomicrographs for chromosome spreads that are suitable for analysis. Once a suitable spread is located, the computer measures and classifies the individual chromosomes and then arranges their images into the format of a conventional karyotype. Other automated features add to the system's capability for chromosome analysis. Plans now call for field testing the device to ready it for commercial production. Final development should result in an instrument useful in mass screening for genetic defects at greatly reduced costs, and in research, clinical, and epidemiological applications.

Physicians often prescribe phenobarbital for the control of seizures in babies and children. The treatment may begin in the first days of life and continue for many years during which time the brain is undergoing a major part of its development. Because of concern for the early and protracted use of the drug on brain development, researchers at the University of California at Los Angeles MRRC have studied the cerebral effects of phenobarbital administration in infant rats. The rat is a postnatal brain developer, achieving its maximum rate of brain growth during the first 21 days of life -- during which period it is particularly vulnerable to deleterious influences. The studies, controlled for nutritional influences, provided data indicating that phenobarbital-treated animals failed to recouperate and were smaller in both body and brain weights than control animals. Further, it appears that nutritionally caused retardation of brain and body growth is not necessarily permanent whereas phenobarbital mediated reductions are unalterable.

The above findings imply that early brain development might be adversely affected by the chronic administration of certain neurotropic drugs. Direct generalization cannot be made from the rat to the human. However, these data introduce a cautionary note prompting continued efforts to further investigate the effects of phenobarbital on brain development and to search for means to assure the safe utilization of the medication which has proven effective in the control of seizures and their adverse effects on development and function.

The safe and successful management of seizures is imperative for the optimal intellectual and emotional development of disabled children, as well as to prevent further central nervous system deterioration from repeated seizures. Investigators at the University of Kansas Mental Retardation Research Center have completed a study which provides a practicing physician with a quantitative basis from which an optimal schedule of drug administration may be derived. This will result in better control of seizures as well as a minimization of adverse effects from drugs.

Investigators at the Albert Einstein MRRC, working with autopsy and biopsy specimens from infants and children with unclassified mental retardation and using special staining and electron microscopy techniques, have demonstrated marked abnormalities of dendritic spine development in the neurones of these children. This is one of the first attempts to apply neurobiological concepts of altered biophysical properties of postsynaptic structures (dendritic spines) in studies of human aberrant behavior.

University of Wisconsin investigators have recently completed a series of studies involving the cardiac component of the orienting response as an index of alteration to speech and non-speech stimuli in six-week old infants. The results indicate that healthy infants born without perinatal difficulty show differential responsiveness to speech and non-speech stimuli. Speech stimuli appear to be more potent elicitors of infant orienting than non-speech. The investigators propose that this differential responsiveness to speech-like acoustic stimuli may be one mechanism involved in developing competence in linguistic processes. Because speech perceptual and performance difficulties appear as problems of significant prevalence in school-aged children who were born prematurely or of low birth weight, groups of infants born at low birth weight are now being studied using the same cardiac orienting response measure.

Infants "at risk" for aberrant development are the object of study by investigators at the University of California at Los Angeles MRRC. Of particular concern to these investigators is the influence of mother-infant interaction on the development of the "at risk" infant. Their studies have demonstrated that differences in maternal care do have consequences for the babies' development. Infants who differed in their competence on particular tests at nine months also differed in the type of caretaking they received. No single care giver behavior was associated with skill in all measures, but particular variables (e.g., face-to-face talking) seemed to be related to performance on several tests. In general, the results suggest the importance not of stimulation *per se*, but of stimulation and interaction contingent to the infant's behavior.

University of Kansas investigators estimate that there are approximately 130,000 children in this country who could benefit from an effective and easy to use non-speech communications training program. Moving to meet the needs of these children, the Kansas researchers are investigating the utility of non-speech responses for teaching communications skills. The programs developed have been shown to be effective with many low-level retarded children with whom other management tactics have failed. However, there remains a variety of basic questions that must be answered before these programs can be generalized to a wider population and a variety of training environments. These efforts are underway and should, when complete, contribute significantly to the effectiveness of the non-speech programs already in existence.

PUBLIC HEALTH SERVICE

Alcohol, Drug Abuse, and Mental Health Administration

National Institute of Mental Health

For at least 25 years, the National Institute of Mental Health has been actively involved in funding mental retardation research. Mental retardation research began as an Institute priority, with a support level growing from $300,095 in 1956 to $2,884,894 (9% of the total research grant awards) in 1961. After 1958 NIMH also supported service projects in mental retardation with the total expenditure of nearly $5,000,000 between 1958 and 1962. In 1962, the National Institute of Child Health and Human Development was established as a part of the National Institutes of Health. This Institute assumed responsibility for some of the developmental research funding which had previously been supported by NIMH and for the major mental retardation research activities.

In 1964 the Hospital Improvement and Inservice Training Programs were established at NIMH, providing another mechanism for funding projects related to mental retardation. The Institute's support of mental retardation activities reached a peak in 1966 with a total of $11.6 million obligated for a combination of research, hospital improvement, training and hospital staff development grants.

In 1967, leadership for retardation programs was turned over to the Social and Rehabilitation Service. At that time, funding for mental retardation and hospital improvement grants shifted to the Social and Rehabilitation Service and in the next several years the unified effort headed by SRS absorbed many of the NIMH mental retardation programs, particularly in the areas of demonstration projects, in-service training, and basic research in child development.

Nine research projects are underway in the area of mental retardation. Of this number, four projects are being undertaken in the area of developmental studies:

1. Research is directed at three psychological problems. The first concerns the development of skills for solving logico-conceptual problems. The aim is to identify and to chart the age-based progress of behavioral processes involved in forming and using class-type concepts for the normal child, then to contrast this developmental sequence with similar assessments of performance in both disadvantaged and mentally-retarded children. The second major problem centers on the utilization of known facts and skills, combining to form what are commonly called strategies, in complex conceptual tasks. The emphasis is on studying the efficiency of information processing by adult subjects. The final, major focus of the program is on an analysis of cross-modal transfer of information, especially in discrimination and concept learning tasks.

2. A study is being conducted of psychological and psychophysiological development of children in the first year of life. In the first phase of research, the subjects are normal children, used in short-term studies to test questions related to expressions of emotion (smiling, frowning), physiological state, and the development of sleep and wakefulness. The infants are observed in the home and are studied through a variety of experiments in the home and laboratory. Physiological indicators (electroencephalogram, respiration, muscle tone, heart rate) of behavior are evaluated. A second study attempts to identify correlates between the maturation of the central nervous system and the development of affective behavior in individual infants with Down's Syndrome, with X-chromosome abnormalities, battered infants are also studied. Data from this

study are compared with that obtained in earlier studies of normal infants.

3. Another project deals with discrimination, remembering and forgetting, attention, learning perception and transfer processes in mentally retarded children.

4. Mental retardation is studied in an institution, community clinic, foster home and day care center. Questionnaires are to be filled in by parents when they apply for admission of their children. Studies of medication, therapy, and deaths of hospitalized patients and of what happens after they leave the hospital are being made. One study reports the extent of retardation among 3,000 families, in age, sex, socioeconomics and ethnic categories. After a ten-year interest, a follow-up is done to examine long-range effects of "labeling". Data is gathered on: the relationship of family and individual personal characteristics, and the influence intervention strategies, or lack thereof, have on subsequent adjustment in the community by impaired persons.

Another two projects deal with intervention techniques:

1. This project is developing laboratory procedures to supplement clinical techniques for describing, predicting and modifying the behavior of severely mentally retarded persons, especially children. Subjects are mentally retarded children under 16.

2. This is a study of autistic schizophrenic children, including retardates, and treatment employing social reinforcement of verbal behavior which imitates that of adults.

Two projects underway involve studies of biological factors:

1. The principal investigator focuses on an understanding of the effects of brain injury in infancy through the use of psychophysiological methods and theory. The problems under study are: First, whether two generalized arousal systems, differentially affecting stimulus processing, can be distinguished; second, whether one of the systems, the "orienting reflex", is relatively difficult to elicit when higher brain centers are not functioning optimally; i.e., during sleep, early infancy, and with brain damage and maldevelopment; and third, whether manipulation of early stimulation can affect development of this system. Subjects of study will be undergraduate college students, normal and premature infants, and mental retardates.

2. Temporal distribution is to be studied, as well as the behavioral and subjectively experienced correlates of telemetered, continuously recorded intermittent electroencephalograph (EEG) abnormalities. Adult and child subjects with Epilepsy, mental retardation, schizophrenia or childhood behavior disorders whose EEG's are distinguished by paroxysmal slow or spike transients, but who do not have overt seizures, are hospitalized and investigated over periods of 24 hours.

In the study of societal factors, one NIMH-funded project has, as its major objective, the examination of the processing of mentally ill and mentally retarded offenders into the Nebraska mental health system. The actual commitment system is compared with the formal statutory system to determine whether and to what extent the actual system differs from the formal statutory policies, commitment procedures, and commitment standards. Communication patterns and decision making factors which account for the incongruities found are described.

The primary method of investigation is interviews with the participants in the commitment process, but court and administrative records are also examined. The five counties in eastern Nebraska are studied.

Nine NIMH training grant projects relate to the mental retardation field:

1. Both predoctoral and postdoctoral training programs of one grant have very extensive opportunities in child and adolescent services, including hospital and outpatient caseloads of children. Schizophrenic, autistic and retarded children are seen.

2. Another project involves a training program for predoctoral interns in a hospital which has both adult and child patients. The trainees gain experience in dealing with child mental illness, with their families, and with the health needs of the community. Training in diagnosis, treatment, counselling, mental retardation, research and group therapy is given.

3. In another developing program, training in mental retardation is being offered as a supplement to the training of the general psychiatric resident as well as to child psychiatrists. Trainees receive instruction in Biochemistry, Genetics, Neurology, and communicative disorders, and in problems relating to retardation. Each trainee also treats two retardates and their families.

4. One NIMH training project is designed to provide intensive one year field training for psychologists in the schools. Assignments to 3 Long Island school systems provide diversified population, preschool to adult in the study of emotionally disturbed, retarded, gifted, culturally disadvantaged, handicapped children. Opportunity is given for group dynamics with student, leaders, and administration.

5. Another grantee is developing a series of four institutes to provide a broad orientation in mental retardation for psychiatric and pediatric residents. Each of the institutes consists of a two-week period of 100 instructional hours and trains 25 participants. Lectures, seminars, and individual assessment of assigned cases constitute the basic teaching methods. Demonstrations focus on retardates with inborn errors of metabolism and on encephalopathies. Seminars cover a wide range of topics, and field trips give special emphasis to management of retardates in the community. Lectures on prevention, genetic counseling, and treatment also are included in the curriculum.

6. The purpose of one of the grants is to teach adolescent psychiatry to medical students through student participation in the Adolescent Service of the Neuropsychiatric Institute. The training program also offers training experience in mental retardation, child psychoanalysis, and forensic psychiatry.

7. The Alabama Department of Mental Health is establishing a program to increase the effectiveness of its entire staff. Although the department is responsible for the state's seven facilities for the operation and administration of the mentally ill and mentally retarded, approximately 90 percent of its patient-care employees have not graduated from college. For this reason, the primary emphasis of the program is on training workers to perform an active therapeutic role instead of functioning merely as custodians. Incentives for training are provided through a career lattice and academic credit leading to associate, bachelor's and master's

degrees. The career lattice, offering horizontal in addition to vertical job mobility, serves as a model usable by other human service agencies. A base for generating future financial support for the career lattice is being established with such entities as the State Legislature and the State Personnel Board. An outside evaluator analyses the program in its formative stages and performs an overall assessment.

8. Doctoral students are provided specialized teaching-parent internships and given experience in conducting community research and training projects. Training is designed to prepare the students to conduct their own programs for instructing professional teaching-parents in the ways of operating community-based group homes for delinquent, emotionally-disturbed and mildly retarded youths. In addition, it prepares the trainees to carry out evaluations of group homes and to follow-up youths who have been in community-based and institutional programs. During their internship, the students work with experienced teaching-parents. Trainees' duties include self-care skills, managing a token economy, administering a family conference, coordinating the program with the courts and the schools, counseling youths' parents, and handling public relations. The effectiveness of the program is evaluated through follow-up of the participants and analysis of trainees' progress during the internship.

9. Undergraduate students are being trained as mental health workers able to provide a full range of effective and practical services to underserviced populations including chronic psychiatric patients, elderly institutionalized individuals, acting-out children and adolescents, and the mentally retarded. Training is provided by the psychology, child study, and education departments in cooperation with twenty service agencies offering field placements lasting an academic year. Basic skills in psychological assessment, group counseling, mental health follow-up, crisis intervention, and home contact are learned. A special effort is made to recruit minority students who wish training. The program is evaluated through assessment of the occupational attainment and performance of graduates.

In the services area, three projects relate, in a significant portion, to mental retardation.

1. South Carolina State Hospital is establishing a treatment program to serve 300 emotionally disturbed, psychotic, retarded, delinquent, or hyperactive patients under 18 years of age. Most of the children and adolescents were previously placed in adult units and treatment programs. Staff is being trained in the use of behavior modification techniques. Close liaison is maintained with community mental health centers and community clinics, since they refer patients to the hospital and provide care after release. An outside consultant aids in evaluation of the program, which involves pretest/posttest data on a broad-based behavioral measure, the Devereux Child Behavior Rating Scale, as well as other measures such as school attendance, grades, behavioral ratings by parents, and arrest records.

2. Another grantee provides comprehensive mental health and retardation services in order to promote community mental health, prevent and decrease mental illness, and offer opportunities for community participation in the delivery of mental health and retardation services. Six basic concerns are: special needs of children with physical, emotional, and learning disabilities; lack of cultural experiences for preschool and elementary school children, need for family life education, especially in junior high school; development of youth programs, behavioral problems of teenagers, and advocacy counseling for young people. Staff members include a counseling psychologist/unit coordinators, a psychologist, an education specialist, two social workers, a public health nurse, and two indigenous community workers. Outpatient services and consultation and education are provided by the Willson Children's Center and Columbus schools.

The target area is the North Central portion of the city of Columbus, with a population of 149,772 in four subareas. Near Northside is a community of newly immigrating Appalachian whites unaccustomed to the city, who reside in a deteriorationg core area. Linden is a stabilizing residential community of upwardly mobile, working-class black families. University is populated by white youth attending Ohio State University. North is a stable, white, middle-class community of an older, more affluent population. The population of the target area is young. Fifty-four percent are under 25 years of age, and 37 percent are under 19.

3. Through its affiliations with multiple neighborhood child care agencies and educational facilities, the Hahnemann Community Mental Health/Mental Retardation Center (HCMHMRC) is developing an early detection, intervention, and facilitator network of services to reach the young, high-risk children in this ghetto catchment area. The new staff positions funded by this grant are created for home agency facilitators and school facilitators. The Home Agency Facilitator staff includes a pediatrician with a psychiatric background, a child development specialist, and a social worker, all of whom train and supervise the nine outreach paraprofessional workers. The professional school facilitator staff includes psychoeducational specialists, a social worker, and a mental health technologist.

The target area is not only the poorest section of Philadelphia but has the highest state poverty rating. The population of 130,000, of whom 56 percent are black, has a multiple array of mental health and economic problems including unemployment, broken homes, low educational level, and alcoholism and drug abuse. Two-thirds of the homes are headed by a single parent, and over one-third of the residents are under 19 years of age. Because only one percent of the 1,300 children treated by HCMHMRC last year were under six years of age, the new focus on early detection and intervention is considered essential if later childhood and adolescent pathology is to be decreased.

The linkage network is a coordinating council, consisting of representatives from day care centers, law enforcement agencies, child health and mental health centers, preschools, the public school system, and foster home placement services. This council, through the home agency and school facilitator staff, seeks out children under seven years of age who are physically, emotionally, and/or culturally vulnerable, handicapped, or abused. The home agency workers act as counselors to families in their homes, as facilitators of appropriate educational, health, and/or social welfare referrals, and as representatives of the community to the linkage network council. The school facilitators are diagnosticians and consultants to teachers. They also coordinate teams who assess a child's disabilities and secure appropriate remedial services. A data bank collects information, monitors the overall project, and assures continuity of care without duplication. Evaluation is based on parental reactions to quality and availability of services, and a comparison of behavior patterns of children who have received help with those who have not.

In June of 1975 a joint multidisciplinary Ad Hoc Consultant Group was created by the Director of NIMH and the Director of NICHHD. This group was created because the two Directors are deeply interested in facilitating the development of all dimensions of the mental retardation research field. This interest extends to contributing, through research activities and information dissemination, to the improvement of the health, mental health and social functioning of the mentally retarded and their families. The Consultant Group has been asked, in the context of the needs of the field and an analysis of current NIMH, NICHHD and Maternal and Child Health activities, to advise the Directors on priorities, areas of overlap and shared responsibility. A preliminary report is due in March 1976 and a final report in June/July 1976.

PUBLIC HEALTH SERVICE

HEALTH RESOURCES ADMINISTRATION

Bureau of Health Planning and Resources Development

Division of Facilities Utilization

Mental retardation facilities have been eligible for and have received construction assistance from the Hill-Burton program since its inception 29 years ago. Up until the passage of the "Mental Retardation Facilities Construction Act" (1963) - P.L. 88-164, Title I, the Hill-Burton program was the primary source of Federal assistance for retardation construction, and administered the Act after enactment until August 1967. Since the advent of the specific construction programs for retardation facilities, the Hill-Burton program has been acting primarily as a back-up resource for construction aid. As of June 30, 1975, a total of 109 retardation projects have been assisted with $56.7 million in Federal funds since the Hill-Burton program began. Hill-Burton personnel in both the HEW Regional Offices and in the State Hill-Burton agencies have provided expert consultation to the retardation facility programs and to many retardation project sponsors or potential sponsors. Hill-Burton consultation is especially valuable where retardation services are to be provided in a comprehensive health care facility or in any combination with other health services.

Division of Facilities Development

A primary objective of the Division of Facilities Development (Hill-Burton program) is to stimulate the modernization and construction of facilities needed to build up an efficient, well-coordinated network of services for the acute care, ambulatory care, long-term care, and rehabilitation of all persons, including the aged and aging. Since the enactment of the Hill-Burton program, the Division has provided assistance for the modernization and construction of 102,949 long-term care beds in chronic disease hospitals, nursing homes, and units of general hospitals.

The need for modernization and construction of long-term care facilities continues at a high level. As the aging population continues to increase, the demand for adequate nursing home care for them must be met. In addition, the enactment of the Medicare, Medicaid and other programs partially removed the economic barriers to care of the aged. State agencies report that 354,000 long-term care beds, including extended care facility beds, need to be modernized or added.

P.L. 93-641, signed on January 4, 1975, extended and extensively revised the Hill-Burton Program. Long-term care facilities will no longer be aided as a separate formula grant category. However, they will be eligible under two types of formula grant assistance: (1) modernization of health facilities, and (2) construction of new inpatient medical facilities in areas which have experienced recent rapid population growth. The same facilities are also eligible for loans or loan guarantees with interest subsidy. A third type of grant assistance is project grants for construction and modernization projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards. The pending FY 1976 Appropriation Act contains $16.3 million for project grants, $57.9 million for formula grants (25 percent or more must be used for outpatient facilities), and nothing for new loan authority.

In addition, the following services provided by the Division of Facilities Development contribute to improved health care of the aged and others throughout the Nation: (1) technical and professional consultation regarding all aspects of facility functional planning, design, maintenance, and construction, which is available to all public agencies, and nonprofit organizations; and (2) guide material relating to the planning, design, equipping, and construction of health facilities, which is continually being developed and distributed.

SOCIAL SECURITY ADMINISTRATION

Purpose

The basic purpose of the social insurance programs (Old-Age, Survivors, Disability, and Medicare) is to provide cash benefits to replace, in part, earnings that are lost to individuals and families when earnings stop or are reduced because the worker retires, dies, or becomes disabled, and to provide health insurance protection to persons 65 and over and to the disabled under certain conditions. This part of the program is contributory and self-supporting. Benefits are wage-related and entitlement to benefits is an earned right. In January 1974, the Supplemental Security Income Program was added to those SSA administers. It provides payments to the needy aged, blind, and disabled, is non-contributory and is financed entirely out of general Federal revenues.

Historical Development

In 1935, when the original social security law was passed, the program was to have provided only retirement benefits to aged workers. In 1939, benefits for dependents and survivors were added and benefits became payable in 1940. Protection against long-term total disability--not only for disabled workers, but also for adult sons or daughters (who became disabled before age 18) of disabled, retired, or deceased workers--was provided by the 1956 amendments. In 1965, health insurance benefits for the aged were added. The 1967 amendments provided benefits for disabled widows and widowers age 50 and over. Since 1958, there have been seven general benefit increases in recognition of the fact that prices and wages have gone up. In 1972, a section of P.L. 92-336 provided for an automatic benefit increase when the cost-of-living rises by 3 percent or more. Effective January 1974, payments under the Supplemental Security Income Program began to qualified aged, disabled, and blind persons, including the mentally retarded.

Economic Impact

Under Title II Programs (Old-Age, Survivors, and Disability)
Mental deficiency is a major factor in more than 72 percent of cases involving dependents or survivors who have been continuously disabled since childhood. In fiscal year 1975, an estimated 248,400 mentally retarded adults disabled in childhood and retarded workers received $343.44 million in benefits.

The regulations contain guides as to the level of severity required in disability cases involving mental retardation. These regulations (published in 1968) have the effect of law and are available to the public and the medical community.

The number of mentally retarded children under age 18 who receive social security insurance payments as dependents of retired, disabled, or deceased workers is unknown, since their benefits are payable regardless of disability. Under social security's "Childhood Disability" provisions, lifetime monthly payments can be made to a person age 18 or over who has been disabled by mental retardation--or other impairments--since childhood. In many cases, the monthly benefits enable the retarded childhood disability beneficiary to be cared for at home instead of in an institution. Furthermore, as more and more retarded people outlive their parents, the program offers reassurance to fathers and mothers who know that financial help for their disabled child will be forthcoming even after their death. About 57 percent of the childhood disability beneficiaries are age 35 and over and 32 percent of them are age 45 and over.

If the parents are dead, a relative who has demonstrated a continuing interest in the beneficiary's welfare, a welfare agency, or a legal guardian may be chosen as representative payee to handle the benefit funds and plan for using them in behalf of the beneficiary. A representative payee receives social security benefits in trust for the beneficiary and, as a trustee, is held accountable for the way in which he uses the benefits.

Under Title XVIII
Medicare benefits are available to any individual, including a mentally retarded individual, who is 65 or over and who meets certain necessary conditions. Therefore, a mentally retarded individual 65 years of age or over who has contracted an illness or suffered an injury is, like any other person in this age group, protected under the Medicare program. (However, the Medicare program does not provide coverage of non-medical care such as personal care, vocational training, etc.) Beginning July 1, 1973, Medicare benefits were also extended to social security disability beneficiaries, under 65 years of age, who have been receiving disability benefits for 24 consecutive months.

Under Title XVI
An estimated 358,400 retarded individuals who are not entitled to benefits under the Title II Disability Insurance Program were receiving payment under the Supplemental Security Income Program by the end of fiscal year 1975.

Activities and Achievements

Since 1970, the Social Security Administration has conducted biennial on-site reviews in State mental hospitals and schools for the retarded. The program focus is an in-depth examination of the way in which these institutions are managing social security benefits on behalf of patients who receive their checks through an institutional official serving as "representative payee."

The observations and conclusions resulting from a State review are, after analysis, communicated to the State Commissioner for his use in the development of improved practices in the State's system. Findings also serve as a basis for SSA program and policy evaluation. The on-site approach is expected to strengthen relationships with the States, improve their understanding of their responsibility for optimum use of benefits when serving as representative payee, and open new channels for the discussion of problems and practices affecting the well-being of all beneficiary-patients in State mental institutions.

SSA has participated in the program to employ the mentally retarded since its inception in 1964. It has also tried to generate interest in the program by private employers and other Federal agencies. In SSA retardates are successfully performing in such positions as mail and file clerks, messengers, operators of printing, xerox, card reader machines, and key punch machines. The SSA experiment with the color coding of file cabinets and cartridges of microfilm has proven highly successful in broadening the employment opportunities for retardates to an area of work which requires a very high degree of accuracy. The retardates have performed their duties in an excellent manner.

The Social Security Administration has published a leaflet entitled If You Become Disabled. A number of others are in stages of preparation or revision.

In cooperation with the Bureau of the Census, the Social Security Administration conducted surveys in 1971 and 1972 of noninstitutionalized adults who had been reported as disabled in the 1970 Census or had become disabled since the 1970 Census. The data collected included demographic characteristics; employment history and present work situation; disabling conditions; job limitations and adjustment; functional limitations and mental health ratings; use of medical care and rehabilitation services; family participation and relationships; and economic resources. Mentally retarded persons age 18 and over who were not institutionalized at the time of the survey are included in these studies. Reports summarizing the data became available last year.

SOCIAL AND REHABILITATION SERVICE

Mental Retardation

Introduction

Since its establishment in 1967, the Social and Rehabilitation Service has administered income support and social services programs for needy Americans, including the mentally retarded.

Three of the eight major Social and Rehabilitation Service components provide income maintenance, medical services and social services for the economically, physically, and mentally handicapped. Responsible for carrying out the legislative mandates concerned with the provision of services for retardates and their families are: 1) Assistance Payments Administration, Social Security Act, Titles IV, Part A and XVI; 2) Medical Services Administration, Social Security Act, Title XIX; and 3) Public Services Administration (formerly Community Services Administration), Social Security Act, Titles I, IV-A, X, XIV, XVI, and XX. Following is a description of the Social and Rehabilitation Service's efforts to assist the mentally retarded.

Assistance Payments Administration

The Assistance Payments Administration has primary responsibility for grants to States for public assistance programs under the Social Security Act, Title IV, Part A, Aid to Families with Dependent Children and Emergency Welfare Assistance; and Title XVI, Aid to the Aged, Blind and Disabled (Guam, Puerto Rico and Virgin Islands only). It is in the disabled portion of the latter program that Federal financial participation is available to help needy individuals, who also may be mentally retarded, through territorially administered public welfare programs.

The Federal expenditures shown in the Table of Obligations for Mental Retardation Activities for Income Maintenance are for Guam, Puerto Rico, and the Virgin Islands.

(Dollars in Thousands)

1975	1976	1977
$255	$274	$293

Medical Services Administration

Title XIX, known as Medicaid, provides Federal matching payments for State expenditures for health care for the poor. In FY 1975, fifty-three States and jurisdictions were participating in Medicaid (Arizona is the only State not participating, however, Arizona plans to begin its Medicaid program on July 1, 1976.)

With the federalization of the adult categories on January 1, 1974, under the Supplementary Security Income (SSI) program, States are not in all cases required to provide Medicaid to all adult recipients of cash assistance under Title XVI, as was the case in the past under Titles I, X, XIV, or XVI. Limited Medicaid coverage of SSI cash assistance recipients will apply in States which, in determining Medicaid eligibility, opt to apply any eligibility criteria from the January 1, 1972 medical assistance standard which is more restrictive than the eligibility requirements for the Federal Title XVI program for aged, blind, and disabled individuals. States which retain any eligibility factor(s) from their January 1, 1972, standard which is (are) more restrictive than the Title XVI eligibility factor(s) must deduct a person's medical expenses from his income in determining eligibility. (They are not required to cover Title XVI cash assistance recipients who otherwise do not meet the January 1972, medical assistance standard.) As of January 1, 1976, fourteen States have restricted Medicaid eligibility of SSI recipients under this option.

Thirty-six States extend Medicaid coverage to all recipients of cash assistance under the SSI program. States also have the option of providing Medicaid coverage to persons receiving a State Supplemental payment, subject to certain limitations. In addition, thirty-two States have elected to cover certain medically needy persons who are eligible for help only with their medical bills and who do not receive maintenance payments.

All Medicaid services included under the State plan (mandatory services include inpatient hospital care, outpatient care, physicians' services, skilled nursing facility services for individuals 21 years of age and older, early and periodic screening, diagnosis and treatment services for children under 21, lab and X-ray services, and home health services; in addition, States may cover a range of optional services including dental care, drugs, eyeglasses, intermediate care facility services, etc.) are available to eligible mentally retarded individuals.

Effective January 1, 1972, P.L. 92-223 transferred intermediate care services to Title XIX as an optional State service and authorized the provision of intermediate care facility services in public institutions for the mentally retarded if the institution provides health or rehabilitative services and if the eligible individuals are receiving active care and treatment. To assure that the Federal dollars made available for such institutional care would lead to higher quality care and services in an improved environment, and not simply to a replacement of State dollars, the legislation contained a provision requiring the States to maintain their own fiscal effort. Thirty-eight States have responded to the new Title XIX authority by adding to their State plan coverage of ICF services in public institutions for the mentally retarded. Prior to January 1, 1972, some 17 States claimed Federal matching in the costs of care in institutions which qualified as skilled nursing home services. It should be noted that because services in the past were being provided to the mentally retarded as skilled nursing home services, the adoption of the intermediate care facility program resulted in a redesignation of facilities in some States. The result is that these facilities are able to provide services at a more appropriate level of care in instances where skilled nursing care is not medically necessary. States, however, continue to provide care for the mentally retarded in skilled nursing facilities where medically appropriate.

Total Federal expenditures for services for the institutionalized mentally retarded (in ICF's only) were estimated to be $210 million in FY 1975. Estimates are not available on the number of Medicaid dollars expended on all other Medicaid services provided to the mentally retarded. It should be emphasized that the Medicaid eligible mentally retarded person may receive the full range of Medicaid services, and receive them on the same basis as the rest of the Medicaid eligible population.

Estimated Federal Expenditures (in Millions)

FY74	FY75	FY76	FY77
NA	$210	$245	$280

Public Services Administration

The Public Services Administration has responsibility for administering the Social Services program authorized under Titles I, IV-A, X, XIV, XVI, and XX, and Child Welfare Services authorized under Title IV-B of the Social Security Act, as amended.

Under Title XX, grants are made to States for services to eligible individuals based on income or public assistance status. States may choose the services they will provide, as long as each service conforms to at least one of the five goals stated in the Act.

Within the broad spectrum of services provided to eligible individuals are those directed to serving the mentally retarded. Some of the services extended to the mentally retarded are:

(1) Day care services which facilitate the child or adult remaining in his own home in lieu of institutionalization.

(2) Short term family foster care during periods of crisis to prevent institutionalization and long term family foster care to provide benefits of family and community living in lieu of institutionalization.

(3) Services directed at attaining entrance to institutional placement where needed and services to move individuals out of institutions where feasible.

(4) Other services which will promote retention of the mentally retarded in their own homes and assist in the development of the individual to his maximum capacity for self care and independence. Among these services are homemaker and chore services, home management, counseling and services to expectant mothers which will help reduce the incidence of mental retardation.

The Basic purpose of the Child Welfare Services program is to protect children from abuse, neglect, exploitation, or delinquency and to assure that they have an opportunity for normal development. Among the recipients of these services are mentally retarded children from all socio-economic groups.

It is estimated that in F.Y. 1977 States will expend $304,800,000 in Federal funds through the Social Services program for services for mentally retarded individuals. Child Welfare Services data on the mentally retarded are not available.

(Dollars in Thousands)

	FY 1974 [1/]	FY 1975	FY 1976	FY 1977
Services to the Mentally Retarded	$202,600	$249,247	$295,800	$304,800

[1/] This amount, the same as reported in the 1976 Hearings, is a preliminary actual. Actual dollars amounted to $198,675,000 (Source: 1974 OA-41.7 (c) reports). Fiscal Year 1974 data has been projected into 1975-1977.

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary of HEW to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became a part of a new Office of Human Development at HEW which focuses on groups of Americans with special needs.

OCD's concerns extend to all children from conception through early adolescence, with emphasis on the formative five years of life and on children who are "at risk" because they have special problems. There are two bureaus in OCD: The Children's Bureau, which provides a wide range of technical assistance services relating to programs for children and families, and the Head Start Bureau which operates Head Start and other innovative early childhood programs.

While OCD does not directly operate any programs specifically for the mentally retarded, the agency has an overall advocacy and leadership responsibility for all children, including children with mental retardation. In line with this responsibility, the Office of Child Development may help plan and recommend programs to deal with mental retardation; develop standards and guidelines for such programs; and provide technical assistance to States and public and private agencies in efforts to help mentally retarded children and youth. OCD works cooperatively with the President's Committee on Mental Retardation, the Office for Handicapped Individuals, the Developmental Disabilities Office, and other HEW agencies.

A. Children's Bureau

The Children's Bureau of the Office of Child Development provides leadership, advice, and technical assistance to States, agencies, organizations, and individuals delivering services to children and their families and to the Department in two areas: the welfare of children at risk and children who are abused or neglected.

Through the National Center for Child Advocacy, the Children's Bureau conducts research and demonstrations, collects, analyzes and disseminates information, and provides technical assistance, under the Children's Bureau Act of 1912 and section 426 of the Social Security Act. These activities are directed toward helping States, localities and private agencies and organizations strengthen their service systems in order to meet the developmental needs of children and their families, through preventive or supportive resources or (where necessary) substitute nurturing environments for the children.

Through the National Center on Abuse and Neglect, the Children's Bureau gathers, develops, analyzes, and disseminates information and new knowledge, conducts research and demonstration, provides training and technical assistance to States and other public and private nonprofit agencies and organizations, and provides financial assistance to eligible States. These activities, which are conducted under the Child Abuse Prevention and Treatment Act, are aimed at assisting service providers in preventing, identifying, and treating child abuse and neglect.

B. Head Start

Head Start enrollment has always been open to handicapped children, but greater emphasis is now being placed on their needs. For FY 1977 Head Start will continue to assure that 10 percent of the enrollment opportunities in each State are available to handicapped children. This is in accordance with the legislative mandate contained in P.L. 93-644, the Community Service Act of 1974. Prior to FY 1976 Head Start had implemented a policy of making 10 percent of the enrollment opportunities nationwide available to handicapped children. Head Start staff members are now receiving special training in working with handicapped children. The handicapped receive the full range of Head Start services as well as special health and education services provided by appropriate agencies in the community.

In addition, 14 experimental projects demonstrate new ways of serving handicapped children in Head Start. Six of these projects are early childhood projects jointly funded by OCD and the Bureau of Education for the Handicapped in the Office of Education, and eight are operated by Head Start programs. The projects will develop a variety of approaches for integrating handicapped and non-handicapped children in Head Start programs. The integration of handicapped children in Head Start is viewed as a valuable experience for all the children concerned since it will help them learn to understand and respect human differences.

OFFICE OF HUMAN DEVELOPMENT

Developmental Disabilities Office
MENTAL RETARDATION

The Developmental Disabilities Office is responsible for a broad range of programs designed to meet the problems of the developmentally disabled including the mentally retarded. The Developmentally Disabled Assistance and Bill of Rights Act, P.L. 94-103, which became law in October of 1975 amends P.L. 88-164, the Mental Retardation Act of 1963, and its successor P.L. 91-517, The Developmental Disabilities Act of 1970. P.L. 94-103 authorizes appropriations for formula grants to States, grants for special projects, and grants to university-affiliated facilities.

These diverse fundings are unified by the common goal of assisting developmentally disabled persons, including the mentally retarded, to achieve and maintain the maximum personal, social and economic independence of which they are capable. Underlying this support is the continuing concern for expanding opportunities and resources available to the substantially handicapped among the developmentally disabled.

Mentally retarded individuals comprise the largest group of developmentally disabled. It is estimated that about 3% of the general population fall into this category. About 87% of the retarded are mildly retarded and therefore able to benefit from education and training, hold a job, and participate in community affairs. The focus now is on the more severely retarded who may also be multiply-handicapped and over the years have been most often found in our public institutions.

It was shortly over a decade ago when attention was called to the plight of the mentally retarded in institutions. A study was made by the President's Panel on Mental Retardation and out of the Panel's recommendations evolved The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) which authorized appropriations for construction of new facilities or remodeling of some to make the public institutions housing mentally retarded persons more livable. At the same time construction of university affiliated facilities was authorized in order to house the training programs that would alleviate the shortage of trained manpower needed to provide skilled services to the retarded.

The Mental Retardation Law was amended by the Developmental Disabilities Services and Facilities Construction Amendments of 1970. The new law was built on the old law but reached out to embrace a larger group of individuals with disabilities similar to mental retardation, which occurred before the age of 18, would be expected to continue indefinitely, and constituted a substantial handicap.

Public Law 91-517 gave strength to the States through a formula grant program. Federal funds became State funds to be disbursed by the State in keeping with the Federally-approved State comprehensive plan. States could set their own priorities to fund State and local projects, could co-mingle funds with those of other State programs to provide a wide range of diversified services through the combination and integration of specialized and generic services of agencies representing areas such as health, welfare, education, and rehabilitation, without imposing a set pattern of services on any one State. A higher Federal share of funds was allowed for poverty areas.

To receive Federal funds under the developmental disabilities program States must have a Federally-approved comprehensive State plan, revised annually, which must include a description of how other State-Federal programs provide for and augment, but not duplicate, these programs. At least nine programs must be taken into account: vocational rehabilitation, public assistance, social services, crippled children's services, education for the handicapped, medical assistance, maternal and child health, comprehensive health planning, and mental health.

Responsibility is placed at the State level for developing strategies for the successful implementation of the program. Use of Federal funds must not result in a decrease in the level of effort at State and local levels in providing services to persons with developmental disabilities. To the extent feasible, this program should stimulate an increase in effort.

The new Act, P.L. 94-103 devotes a new section to Special Projects of which not less than 25% of the special project money must go to Projects of National Significance. These funds may be used for projects which will:

1. improve the quality of services;
2. establish demonstration programs which hold promise of improving services;
3. provide public awareness and public education programs aimed at eliminating environmental barriers;
4. collect and disseminate information;
5. provide technical assistance;
6. provide for training of specialized personnel;
7. demonstrate new or improved techniques in the provision of services
8. coordinate available community resources
9. demonstrate provision of services to developmentally disabled persons who are economically disadvantaged.

P.L. 94-103 authorizes support for university affiliated facilities. This support provides for administrative, operating costs, service delivery and interdisciplinary training of specialized personnel.

Because the problems of the mentally retarded are evident in all aspects of their lives, it is important that persons providing services understand, and be able to deal constructively with the complex interrelationships. For example, health problems bear heavily on educational services, and both are affected by social conditions. It is important, therefore, that more complex cases of mental retardation have access to a variety of interrelated services, provided by persons with broad knowledge of these relationships. This training is provided by the UAFs which draw on a number of schools and colleges within the university, and provide practical experience in treating retarded persons.

The UAFs also provide consultation, technical assistance, short-term training and other forms of assistance to agencies serving the developmentally disabled.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

MENTAL RETARDATION

Under the public rehabilitation program, grants are made to State vocational rehabilitation agencies to assist them in providing rehabilitation services to mentally and physically disabled individuals who have substantial employment handicaps and who can reasonably be expected to be rehabilitated into gainful employment. Among the services provided by State vocational rehabilitation agencies are comprehensive medical, psychosocial and vocational evaluation; physical restoration; counseling; personal adjustment, prevocational and vocational training; maintenance and transportation during the rehabilitation process; placement in suitable employment; services to families of handicapped people when such services contribute substantially to the rehabilitation of the handicapped client; and follow-up services to assist handicapped individuals to maintain their employment.

Recent years have seen dramatic advances in the provision of vocational rehabilitation services to the mentally retarded. The retarded now comprise about 12% of the people rehabilitated from all categories of disability by the State-Federal program of vocational rehabilitation. In 1975, about 41,500 mentally retarded people were rehabilitated, and it is expected that approximately 44,000 will be rehabilitated in 1976.

Basic to the vocational rehabilitation effort has been the growing reliance on counselors and other vocational rehabilitation staff who work exclusively with retarded clients. This specialized staff may be assigned to local vocational rehabilitation offices, schools, institutions, sheltered workshops, or other facilities serving the mentally retarded. By concentrating their attention on the mentally retarded clients, these counselors are successfully developing rehabilitation plans based on the special problems of the retarded, and are able to be broadly responsive to the needs of both the client and his family. As special vocational rehabilitation programs and facilities for the retarded continue to be developed and expanded, the number of specialized counselors within State vocational rehabilitation agencies is expected to increase.

The specialized vocational rehabilitation staff working with the mentally retarded has been particularly effective in the development of cooperative vocational rehabilitation-special education programs designed to assist the retarded young person make a satisfying transition from school to work. These cooperative programs are found in many communities throughout the country and have greatly strengthened both special education and vocational rehabilitation efforts with the mentally retarded. The cooperative program structure varies from State to State, and the variety of approaches is extraordinary. In some States, program administration is Statewide and in others there are separate agreements with individual school districts. Some programs function only to serve the mentally retarded, while others include youth with all kinds of disabilities. In some States, only vocational rehabilitation and special education are administratively involved, while in others representation includes vocational education.

Most cooperative arrangements have brought about the development of vocationally-oriented curricula within the schools. All of them, however, provide comprehensive evaluation of the retarded young person's vocational rehabilitation potential, personal adjustment and pre-vocational training, counseling, on-the-job training and work experience, job placement, follow-up and related vocational rehabilitation case services. The number of retarded young people enrolled in cooperative vocational rehabilitation work-study programs is increasing steadily as new programs are developed. These cooperative programs have proven themselves effective in reducing the school dropout rate of retarded youngsters and have provided a technique for continuous service to youngsters during the school years when they are best able to benefit from them.

Another emphasis of State vocational rehabilitation agencies has been the establishment of rehabilitation facilities, such as comprehensive rehabilitation centers, evaluation centers, occupational training centers, workshops, half-way houses, and other specialized facilities serving the mentally retarded. Such a rehabilitation facility may be established by State rehabilitation agencies, or by the State agency in cooperation with other public or private agencies.

State vocational rehabilitation agencies may assist in the construction of rehabilitation facilities in a variety of ways. They may construct new buildings; alter, expand or renovate existing buildings; purchase necessary equipment; and provide initial staffing support. In all cases, State or private financial resources must be used to match Federal funds.

Other rehabilitation facility improvement activities are: (1) a program of technical assistance consultation to provide workshops and other facilities with special consultation services in such areas as workflow, safety engineering, contract procurement, and vocational evaluation and adjustment; and (2) projects to share in the cost of providing training services for handicapped individuals in public or nonprofit workshops and rehabilitation facilities. Federal financial participation in the training services grant program may assist in the cost of such services as training in occupational skills, work evaluation, work testing and the provision of occupational tools and equipment necessary for training purposes and job tryouts.

Rehabilitation Training in mental retardation has focused on rehabilitation counselor training by supporting field units in which student trainees can concentrate their practicum experience in work with this client population. Such grants also support field instructional faculty. Recently, six Regional short-term training seminars with a special focus on mental retardation and other developmental disabilities were supported under the rehabilitation training program. Seminar titles and course sponsors were: Preparation of the Developmentally Disabled for Adult Life - Illinois State Pediatric Institute; Serving the Severely Retarded - Puerto Rico Division of Mental Retardation; Interagency Approach to the Rehabilitation of the Mentally Retarded - Texas Tech University; Service Coordination for the Developmentally Disabled - University of Colorado Medical Center; A Developmental Process for the Developmentally Disabled - University of Wisconsin; Generic Training for Services to the Mentally Retarded - Weber State College.

Number of Rehabilitations with Mental Retardation

	Persons Rehabilitated	
Fiscal Year	Total	Mental Retardation
1973	360,726	40,159
1974	361,138	46,600*
1975	324,039	41,500*
1976	334,200	44,000*
1977	353,000	48,000*

*Estimated

Rehabilitation Research and Evaluation

Under the public rehabilitation program, grants are made to States and public or non-profit agencies and organizations, including institutions of higher education, to pay part of the costs of projects for the purpose of planning and conducting research, demonstrations and related activities which assist in the provision of vocational rehabilitation services to handicapped individuals, including the mentally retarded.

In spite of the evidence that the total number of retarded individuals in residential facilities has been slightly reduced in recent years, there is evidence that readmissions to public institutions have increased. Readmissions constituted 8 percent of the total admissions in 1968, as opposed to about 19 percent of the total admissions in 1970 and 27 percent in 1971. Research on post-institutional adjustment of mentally retarded individuals has shown that their chances of success in work and community living are highly related to the adequacy of services made available to them at critical times following discharge from the institution.

Research in the Office of Rehabilitation Research and Evaluation, Rehabilitation Services Administration, will continue focusing on the services that enhance the development of human qualities, capabilities and attributes to the maximum; those which bridge the gap between attained competency and what is required for normal social independence; and those which protect the person from excessive hardship, loss of livelihood, sudden disaster, neglect and exploitation and other threatening circumstances beyond his control. These might be grouped under "developmental services," "supportive services" and "protective services." The differences in need for each kind of service between a retarded person and so-called normal one is not really a difference in kind, but one of degree. Obviously, the more severe the degree of retardation, the greater the need for community services, and the greater the gap that is likely to remain between attainable abilities and those required for normal independence and social functioning. The goal is to lessen the dependence on special forms of supportive services and maintain the person's social and vocational adjustment to the point that he can meet the demands placed upon him and reduce the likelihood that he be placed or returned to an institutional setting.

Research and Training Centers

Under public law, grants are made to three Rehabilitation Research and Training Centers in Mental Retardation, which were established by Congress in 1965, to conduct multidisciplinary programs of research on the major psycho-social, vocational, and personal adjustments in the lives of the mentally retarded persons. The training activities in which each Center is involved are geared toward wide dissemination and utilization of new knowledge resulting from research findings.

In response to HEW's positions on the reduction of populations in institutions, and with the increased recognition of the need to develop adequate alternatives to long-term institutional care, the research projects conducted by these Centers are directed toward facilitating the integration of the mentally retarded persons into independent or semi-dependent community life with productive employment as the ultimate objective. The three Centers are located at the Universities of Wisconsin, Texas Tech and the University of Oregon.

University of Wisconsin

Since its initiation in 1966, the initial organization of the research phase at the University of Wisconsin Research and Training Center's research programming patterns have been concerned with the problems of the mental retardation process of the "cultural-familial" mentally retarded who derive from a disadvantaged population group. This research approach was initially established as a unique focus of the research program when little knowledge was available about the relationships of poverty to mental retardation. A longitudinal pilot project entitled, "The Milwaukee Project," was designed to determine whether "cultural familial" or "sociocultural" mental retardation could be prevented through a program of family intervention beginning early in infancy. This project differs from previous "enrichment" or "early childhood education" programs in its focus on subjects who are, in the epidemiological sense, at very high risk of being incorrectly identified as retarded and in the commencement of intervention in early infancy rather than a later age.

Currently, the Milwaukee High Risk Population Rehabilitation Program is continuing to demonstrate that cultural familial retardation can be prevented through early intervention, and retarded mothers (usually welfare recipients) can be rehabilitated and trained for employment. Of major significance is the continued development and implementation of research findings by other agencies.

A national institute to disseminate the findings of the Milwaukee Study and other similar areas was conducted by the Wisconsin Research and Training Center. Participants representing rural and urban areas and all ethnic groups participated. There was sufficient interest and desire to plan for the establishment of twelve additional demonstration centers throughout the country. Another objective is to demonstrate that such programs can be organized within communities if existing funds are coordinated. The University of Wisconsin Research and Training Center will coordinate this future effort and provide assistance to communities which participate.

Based upon the success of the cultural-familial mental retardation research program in preventing mental retardation in high risk families, the Center's research will continue to focus on the adolescent and the young adult mentally retarded to determine the factors that lead to social and legal conflicts and vocational inadequacy. Intervention techniques which may be effective in minimizing or preventing the development and manifestation of serious problems of adjustment will continue to be developed and tested.

The second major focus of the University of Wisconsin Research and Training Center's Research Program is entitled, "Crises Intervention Rehabilitation for the Severely Mentally Retarded Adults," which concentrates its efforts in developing practical rehabilitation techniques for use with the difficult to rehabilitate severely mentally retarded individuals who are referred from active rehabilitation facilities programs.

Texas Tech University

The core areas of research at the Texas Tech University Research and Training Center have emerged as priority areas perceived by the Rehabilitation Agencies in the Region as crucial in the rehabilitation of the mentally retarded. This Center was established in 1972.

Research in the area of the "work potential of the retarded" explores the capacities for employment of the mentally retarded persons, including those who are not traditionally eligible for vocational rehabilitation services. The second area of research has been crystallized in response to expression of need by State rehabilitation agencies and concerns the roles of the counselors in habilitating mentally retarded clients. Research is directed towards development and evaluation of empirically based orientation and in-service training for professional and para-professional rehabilitation personnel--specifically training which equips the rehabilitation personnel to work more effectively with the mentally retarded client.

The third research area focuses broadly on community adjustment and training of the mentally retarded. Studies in group homes are examining environmental variations among community residences, community attitudes relevant to group homes, adjustment problems in transition from institutions to community, and the impact of community residence in client functioning.

The fourth area is concerned with the special needs of the multiply handicapped mentally retarded individuals. Research is focusing on investigating the prevalence of hearing impaired mentally retarded, examining the current patterns of service for such persons, and generating recommendations regarding needs for service.

University of Oregon

Since its inception in 1966, the University of Oregon Research and Training Center has been involved in research relating directly to the problems of adjustment of the mentally retarded living in the community. Over the past two years there has been an increased emphasis on directing research toward the evaluation of critical service programs for the mentally retarded vocational rehabilitation clients. One major thrust in this direction has involved a series of studies related to evaluation of work-study programs and rehabilitation services for the retarded young adults. The relationship of participation in these programs to post-high school community adjustment has been of ultimate concern.

Continuing its focus on the vocational aspects of community programs, based on the view that a degree of vocational independence is a central element in the achievement of normalization even for the profoundly retarded, much of the Center's current research is being designed to answer the practical questions which will aid in the daily operations of community programs which do provide vocational opportunities to the severely retarded.

Training Activities

The basic objectives of the Centers' training programs are, "...the mobilization of efforts toward: the expansion and strengthening of training in rehabilitation fields where shortages of trained personnel are acute; the training of researchers and other professional and para-professional rehabilitation personnel; incorporating rehabilitation education into all rehabilitation-related university graduate and undergraduate curricula; and improving the effectiveness of rehabilitation services by conducting in-service and continuing education programs including seminars, workshops, courses of study, conferences and demonstrations which will enhance the skills of students, professionals, para-professionals, volunteers, consumers, parents and other personnel involved in the rehabilitation process." Inasmuch as solutions to rehabilitation problems, in most instances, require the coordination of biomedical, psycho-social, engineering, educational, and vocational rehabilitation disciplines, the Center programs encompass training into all these components of rehabilitation that will lead to employment. This training is often conducted in cooperation with local and State rehabilitation agencies and facilities.

Of all the various social agencies with which the Centers maintain contact, the most extensive and intensive relationships are always maintained with the State Division of Vocational Rehabilitation. These relationships can be described in terms of four general categories: (1) in-service training; (2) consultations and technical assistance; (3) research collaboration; and (4) assistance in determination of Center research and training priorities.

Collaboration in the area of in-service training is clearly the most extensive component of these relationships. As being documented in the training sections of the Centers' Annual Progress Reports, more rehabilitation counselors have been provided training than members of any other professional groups. This is occurring because of the close contact that is maintained between each Center and the State rehabilitation agencies. The University of Oregon alone provides training for vocational rehabilitation personnel within twelve States.

Consultation services provided by a Center include a wide range and variety of assistance. The Texas Tech Research and Training Center is conducting a technical assistance project which is supported by the Texas Developmental Disabilities Planning and Advisory Council. During its first year of operation (FY-1975), this project has over 760 contacts with some 109 agencies serving the mentally retarded in Texas alone. A few of the areas in which technical assistance and consultation were provided are: management, program planning and evaluation, needs assessment, sub-contract procurement and bidding, wage and hour regulations, legal requirements for work and activity centers, training strategies for the mentally retarded, sheltered living, prosthetic devices for daily living and behavior modification programming. A diverse list of over 150 potential consultants has been developed.

In research collaboration, which has significant benefits to both the Center and the agency involved, during the last year the counselors from the Oregon Rehabilitation Division have assisted the Center in determining the predictive validity of the Social and Pre-Vocational Battery for the Mentally Retarded developed by the Center. At the same time, the State agency will receive the Battery for future use.

In addition to the Central Office, assistance to a Center in determining its research and training priorities is provided by Regional Advisory Councils whose memberships include the Regional, State and local rehabilitation agencies and facilities, and consumer groups, and represent a broad array of services to the mentally retarded.

Mental Retardation Projects in Special Foreign Currency Countries

There are six Research and Demonstration Projects in the field of mental retardation currently being supported through the Special Foreign Currency Program. These are located in Israel, Poland, Tunisia and Egypt. It is expected that two new projects in mental retardation will be initiated under this Program in 1977.

FEDERAL PROPERTY ASSISTANCE PROGRAM

The Office of Federal Property Assistance, Office of Facilities Engineering and Property Management, within the Office of the Assistant Secretary for Administration and Management, carries out the responsibilities of the Department under the Federal Property and Administrative Services Act of 1949, as amended, which makes surplus Federal real and personal properties available for health and educational purposes. The properties which become available under this program are those that have been determined by the General Services Administration as having no further Federal utilization.

Surplus personal properties generating at Federal installations in the United States, Europe and Southeast Asia, are screened to determine those which may be needed and usable by eligible institutions throughout the country in conducting health and educational programs. Properties determined to have such need and usability are allocated by the Department of Health, Education, and Welfare for transfer to State Agencies for Federal Property Assistance which have been established in all States. These State Agencies secure the properties, warehouse them, and make the distribution to eligible donees for health and educational uses within their respective States. The only costs to the eligible donees are the handling and service charges which are assessed by the State Agencies.

In the case of real properties which have been determined to be surplus to Federal needs, notices of their availability are sent to potentially eligible applicants, either by the State Agencies or the Regional Program Directors for Federal Property Assistance located in our ten regional offices. Real properties available for removal from their site for relocation are conveyed by agreement of sale with restrictions as to the use of the facilities, which run for a period of 5 years. These properties are conveyed with a 100 percent public benefit allowance applied against the sales price. Land, or land and buildings together with other improvements, are conveyed by deed which contains restrictions as to use for a period of 30 years. These properties are conveyed with public benefit allowances ranging up to 100 percent applied against the sales price. The only other costs to eligible transferees are "out-of-pocket" Federal costs, i.e., appraisals, surveys, etc.

Schools for the mentally retarded are eligible to acquire surplus real and personal property. In the case of personal property, such a school must be operated primarily to provide specialized instruction to students of limited mental capacity. It must be tax-supported or nonprofit and exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. It must operate on a full-time basis with a staff of qualified instructors for the equivalent of a minimum school year prescribed for public school instruction of the mentally retarded. It must also demonstrate that the facility meets the health and safety standards of the local governmental body.

An applicant for real property must be a State, or a political subdivision or instrumentality thereof; a tax-supported educational or public health institution; or a nonprofit educational or public health institution which has been held to be exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. Its proposed program of use must be fundamentally for an educational or public health purpose; i.e., devoted to academic, vocational or professional instruction, or organized and operated to promote and protect the public health. Real property may be put to a joint use, namely, for the training of the mentally retarded as well as the physically handicapped. Conveyances have been made for hospital use where, as a part of the total program portions of the facility are used for the treatment and training of the mentally retarded.

Available personal property may range anywhere from a nail to an electronic computer. Many items have never been used before. Real properties may consist of all types of buildings which are removable, land with or without structures and other improvements--such as utility lines, sewer and water systems, etc.

Pamphlets giving more detailed information as to eligibility of organizations for both surplus real and personal property, as well as additional information in connection with the Federal Property Assistance Program, and a directory of the State Agencies for Federal Property Assistance and the ten Regional Offices of the Department, may be obtained from the Office of Federal Property Assistance, Department of Health, Education, and Welfare, Washington, D.C. 20201.

Real property has been conveyed for many and varied programs related to the education, training, rehabilitation, and care of the mentally retarded. Many programs are operated by States as part of their regular educational programs, or through special educational services. The State of New York operates such programs through its Board of Cooperative Educational Services (BOCES). Many parcels of surplus property have been conveyed to BOCES for training the handicapped and retarded, including 4.93 acres of land and 5 buildings at Suffolk County Recreation Annex, transferred during this year.

Many other States operate schools or hospitals on surplus land, such as the Belle Chase State School located at the former Belle Chase Ammunition Depot in Louisiana; Missouri's Springfield Regional Diagnostic Clinic at the O'Reilly General Hospital site; Illinois' McFarland Zone Center at Lincoln Ordnance Depot in Springfield; New Mexico's Rehabilitation Center at the former Walker Airforce Base at Roswell, and many others.

Many programs are operated by other than States, such as Counties, local school boards, and associations for the retarded. Many of these are included in the transfers made during the past fiscal year, such as 5 acres at the Cyane Naval Housing Project in San Diego, California conveyed to Friends of Handicapped Children; 85 acres and 50 buildings at the Scott Facility Annex in Illinois, deeded to St. Clair Associated Vocational Enterprises; 2.3 acres, formerly a grain storage bin site near Chillicothe, Ohio, for training of retarded by the Ross County Board of Mental Retardation; the former Tiffin, Ohio Post Office, conveyed to Tiffin County Board of Education for special education, including courses for the mentally retarded; 2.4 acres and one building at Oak Ridge, Tennessee, to Anderson County Board of Education; as well as two parcels in Texas acquired by the City of Mineral Wells and the County of Webb for these purposes. In addition, an 11-acre parcel at Davis-Monthan AFB in Arizona was conveyed to the State to expand its existing school for the retarded.

Through June 30, 1975, 5,553.94 acres of land and 957 buildings have been transferred to institutions for use in programs serving the mentally retarded. These properties originally cost the Government $55,458,684 and had a fair market value of $22,116,420. Of this total, 143.33 acres of land and 63 buildings, costing $6,041,268 and having a fair value of $1,466,135, were conveyed during FY 1975.

Schools for the mentally retarded operated by State and local agencies of government, as well as many nonprofit schools operated by Associations for the Mentally Retarded or Cerebral Palsy, are major users of the surplus personal property acquired through the State Agency Distribution Centers of their States. During FY 1975, surplus properties having an original acquisition cost of $324,527,101 were donated to eligible public health, educational and civil defense donees in the States. Representatives of schools for the mentally retarded should establish their school's eligibility with their State Agency and make regular visits to their State Agency Distribution Center(s) to inspect available properties and select items needed by their school.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PROGRAMS FOR MIGRANT AND OTHER SEASONAL FARMWORKERS

Opportunities for the economic and social advancement of the population of migrant and other seasonal farmworkers are limited for a variety of reasons including high seasonal unemployment, limited coverage under labor legislation, undereducation , poor health status and unfulfilled housing needs.

The Department of Health, Education and Welfare has the responsibility for funding and administering four programs which are designed to meet some of the needs of this special population. They are as follows:

1. Migrant Education - Office of Education

    Legislative authority:

    Elementary and Secondary Education Act of 1965, as amended; Title I (20 U.S.C. 241b)

    Objective:

    To provide grants to States for programs and projects to meet the special educational needs of children of migratory agricultural workers and fishermen, and to coordinate with similar programs and projects in all of the States.

    Programs: Grants to States

2. Special Vocational Rehabilitation Projects - Rehabilitation Services Administration

    Legislative authority:

    Rehabilitation Act, section 304 (c)

    Objective:

    To provide rehabilitation services to handicapped migratory and other seasonal farmworkers.

    Programs:

    Demonstration projects in selected States.

3. Migrant Head Start - Office of Child Development

    Legislative authority:

    Economic Opportunity Act of 1964, as amended; section 222 (42 U.S.C. 2809)

    Objective:

    To expand child-care facilities available to children of migrant families and to develop a network of cooperating grantees to serve these children both while migrating and while they are in their home base areas.

    Programs:

    Child care and Head Start services

4. Migrant Health - Health Services Administration, Bureau of Community Health Services

    Legislative authority:

    Public Health Service Act, as amended (42 U.S.C. 242h)

4. (continued)

Objective:

To provide grants to public and non-profit institutions and organizations to finance part of the cost of (1) establishing and operating family service clinics and (2) special projects to improve health services and health conditions for domestic agricultural migratory and seasonal workers.

Programs:

Full-time comprehensive health service projects
Part-time comprehensive health service projects
Part-time medical service projects
State-coordinated projects offering direct health services in several counties
Other health service projects

OFFICE OF EDUCATION

REPORT ON MIGRANTS

(Fiscal Year 1977)

Title I of the Elementary and Secondary Education Act, Public Law 89-10, as amended, provides payment to State educational agencies for assistance in educating migratory children of migratory agricultural workers and migratory fishermen.

Funds are used for programs which are designed to meet the special educational needs of such migratory children, and to coordinate these programs and projects with similar programs and projects in other States.

A migrant student record transfer system is located in Little Rock, Arkansas. Teletype terminals are located in 146 strategic areas serving the 49 States and Puerto Rico. This transfer system is funded by an equal percentage of each State's allocation set aside by the U.S. Commissioner of Education. The purpose of the system is to provide to school districts enrolling migratory children rapid transmittal of pertinent general, health and academic data for each migratory child.

This system was developed through the cooperative efforts on behalf of the participating States through the work of an interstate committee. The program direction, specifications for the computer, and the manner by which the system was to be operated was the task given and completed through this cooperation.

Because of the mobile nature of the target population, traditional educational practices needed to be adapted to meet this transitory state of migrant children in an educational environment. Since the inception of the program, States have undertaken this challenge and have developed unique approaches to meet these specific conditions. These efforts have resulted in the earn and learn vocational programs in Florida, New Jersey and North Carolina, in which career awareness and salable skills have been introduced such as supermarket cashiering, assembly line techniques and quality control, automotive tune up, and paramedic training just to mention a few. These activities provide a small monetary compensation to the migrant student which places relevancy in instructional services acknowledging the economic situation in which the migrant finds himself.

The California Mini-Corps Program was designed to utilize current and former migrant children as tutors and program assistants. It has had a two-fold impact: 1) provides opportunities for employment of former migrants thus permitting them to pursue further educational opportunities in junior colleges and colleges, and 2) provides a model for individualizing instruction to further the educational achievement level of underachieving migrant children.

Since the inception of the program much attention has been focused on the language development of migrant children. These language development efforts have taken the form of bilingual and bicultural instructions, the development of oral language skills, and programs for English as a second language. The migrant program has made a reality of the inservice training of teachers as a basic component of all State activities to facilitate the adequate and efficient delivery of services to migrant children. Because of the mobile nature of the children, cooperation between sending and receiving States is required in order to insure a continuum of educational service. As a result of that challenge the States have cooperated in exchanging teachers, mobile educational facilities, cooperative workshops and conferences, and consultant services.

Currently there are three major interstate program thrusts. The States of Minnesota, Wisconsin, Illinois, Indiana, Ohio, and Michigan have formed a consortium of States to cooperatively plan and implement programs in their respective areas. [illegible] States have assumed a similar responsibility regarding their migrant population. The States on the east coast have already demonstrated their cooperation and concern in interstate efforts by meeting at least annually to share ideas and discuss concerns relating to the east coast migrant stream. In May of 1976, the State of Pennsylvania will co-host the 9th Annual National Conference on Migrant Education. This conference in initiated, organized and participated in by all the States providing educational services for migrant children.

An estimated 340,000 migrant children were served under this program in 1975. This figure will rise to approximately 530,000 in 1976 and 675,000 in 1977. These estimates are based on the expanded eligibility provision of Public Law 93-380.

[illegible] Programs for Migrants

	1975 Actual	1976 Estimate	1977 Estimate
Elementary and Secondary Education: Educationally Deprived Children (Title I)	$91,953,160	$97,090,478	$130,000,000
Total	$91,953,160	$97,090,478	$130,000,000

Obli[illegible] Migrants

	1975 Actual	1976 Estimate	1977 Estimate
Occupational, Vocational, and Adult Education			
Adult education-grants to States	$1,200,000*	$1,200,000*	$1,200,000*

* Figures are based on percentages

Vocational Education

Matching grants are made to States on a formula basis to assist States in maintaining, extending, and improving existing vocational education programs and to develop new programs in vocational education. Many States have programs assisting children of migrant workers but the vocational education reporting system does not collect data to identify these children separate from other children. There is also no accounting for dollars by this category.

Adult Education

Formula grants are made to State departments of education under the Adult Education Act of 1963, as amended. These grants assist the States in establishing and expanding programs of adult public education so that adults can continue their education through completion of secondary school and secure job training to enable them to be more employable.

Adults sixteen years of age and older (including migrants) with less than a twelfth grade level of education are eligible for participation in this program. However, many State and local education agencies do not keep records of how many migrants participate in local programs or the amount of funds expended on such participation. Starting in Fiscal Year 1976, the adult education reporting system will begin to collect data on migrants and then validated reports of migrant participation will become available.

Obligations for Programs for Migrants

	1975 Estimate	1976 Estimate	1977 Estimate
Library Resources:			
Public Library services (LSCA, Title I)	$ 80,000	$ 60,000	-0-
School library resources (ESEA, Title II)	190,000	200,000	200,000
Total	270,000	260,000	200,000

Under the provisions of Title I of the Library Services and Construction Act, a State formula grant program, funds are made available for the development of programs designed to provide library services for the disadvantaged in rural areas and to extend library service to geographical areas and groups of persons without such service.

Library services provided specifically for migrants are bookmobile services and library resource center services. Projects in California and Kansas illustrate these services.

California - "Biblioteca Ambulante", a mobile unit, operated in four counties of central California. This continuing project is providing library service primarily to migrant workers, labor camps, and disadvantaged areas--isolated rural areas of Fresno, Madera, Kings, and Tulare counties and the city areas of Hanford and Tulare. This bookmobile is designed for audio visual materials as well as books, and Spanish-speaking personnel are serving the Spanish-American population.

With the continuation of Biblioteca Ambulante services it is hoped that the ultimate goal of the project can be attained: to direct the rural disadvantaged Mexican-Americans to utilize public library facilities and to direct the public library to consider and fill the needs of Mexican-Americans who constitute a major part of the area's growing population. It is a demonstration project for migrants who have a right-to-read.

Kansas - Services in Kansas provide special "Reach-out" Reading Centers for the migrants moving through the Southwest Kansas Library System. Of the target group of approximately 2,300, at least 500 were identified as users in first year of Teaching Collections of Teaching Collections of books are made available to migrant groups wherever they are camped and when possible they are encouraged to make use of special services at established library branches and mobile units.

Title II of the Elementary and Secondary Education Act grants funds to the States for the provision of school library resources, textbooks, and other instructional materials for the use of children and teachers in public and private elementary and secondary schools. Certain target groups of children who have greater need for materials have more made available to them under the States' relative need formulas. One such group is the children of migrant workers. Examples of ESEA Title II projects benefitting these children are:

Sunny Ridge School, School District No. 131, Nampa, Idaho - Five learning centers for study, research, and recreation are provided for primary school pupils (largely children of migrant farm workers). Emphasis is placed upon improving listening, speaking, writing, and reading skills through extensive use of printed and audiovisual materials and audiovisual equipment. Audiotapes are used to provide new listening and learning experiences. The enrichment programs include use of films, filmstrips, books, and magazines on subjects of cultural interest as well as subjects that aid in the achievement of instructional objectives. ESEA Title II funds supplied the materials.

Pershing County School District, Lovelock, Nevada - A project to enable pupils to reach their maximum potential in reading through the use of materials geared to individual needs serves all pupils in the four schools of the county. These schools had particular need for bilingual materials for children of migrant parents, all Spanish-surnamed. To guide their pupils in the use of these materials, teachers and librarians are becoming more sensitive to the cultural patterns of their pupils, recognizing that these patterns influence their values, interests, motivations, and behavior. Another special need of the schools was for very easy reading material for pupils in the first four grades. All four schools had a need for media to support the general elementary and secondary school curriculum. Heavy emphasis is placed on reading skills in all grades. Pupils in the first three grades spend a considerable share of the day in learning to read. In the middle grades, teaching is directed toward reading for meaning and development of study skills. In the secondary school, teachers use many methods of instruction that require pupils to read, interpret, and analyze, and to locate, select, organize and interpret information. The materials were acquired under ESEA Title II.

Obligations for Programs for Migrants

	1975 Actual	1976 Estimate	1977 Estimate
Elementary and Secondary Education:			
Educationally deprived children (Title I)	$91,953,160	$97,090,478	$130,000,000
Supplementary services	---	---	---
Subtotal	91,953,160	97,090,478	130,000,000
Occupational, Vocational, and Adult Education:			
Adult education-grants to States	1,200,000	1,200,000	1,200,000
Library Resources:			
Public library services (LSCA, Title I)	80,000	60,000	-0-
School library resources (ESEA, Title II)	190,000	200,000	200,000
Subtotal	270,000	260,000	200,000
Total	93,423,160	98,550,478	131,400,000

OFFICE OF HUMAN DEVELOPMENT

MIGRANTS

Rehabilitation Services Administration

The estimated migratory population in the United States is 1,000,000. From the efforts conducted to date and from data obtained from other programs with experience in migratory labor problems, it is estimated that at least 40,000 persons would be eligible and feasible for vocational rehabilitation services.

Appropriations for Special Projects for vocational rehabilitation services to handicapped migratory agricultural workers and seasonal farmworkers were made available for the first time in 1974 under Section 304(c) of the Rehabilitation Act. Eight projects were established in the following States which are currently in operation: California, Florida, Idaho, New Jersey, New York, Oregon, Texas and Wisconsin. Six Regional Offices are involved in the administration of these projects. Recent site visits to the projects confirm the fact that they are providing badly needed vocational rehabilitation services to this underserved minority group.

In accordance with Section 304(c), cooperation has been obtained from the Office of Education, the Public Health Service, and the Department of Labor, all of which sponsor projects for migratory workers.

Data provided by other programs substantiate proportionately greater health problems and related disabling conditions, and the necessity for concentrated services, including outreach efforts to familiarize migrants about services and to encourage them to modify their migratory patterns in order to be served. Emphasis which can be most effectively focused through this special program is necessary to deliver services, in cooperation with other programs, to migrants who present such unique and extensive problems.

In April 1975, a meeting was held in Washington which was attended by project directors, and officials from State and Regional Offices where information was exchanged on providing rehabilitation services to handicapped migratory workers. Also participating were RSA staff and representatives from cooperating Departments, agencies and consumer groups.

RSA can make a singificant contribution toward the solution of the complex problems of the migrants, particularly as they are related to the preparation for and return of migrant workers to more stabilized employment. The need for extending and improving the delivery of social and rehabilitation services to greater numbers of these people is becoming more urgent in light of USDA projections that there will be a reduction of 55% of the migratory workers force by 1976 due to mechanization.

Rehabilitated Migratory Agricultural Worker and Seasonal Farmworkers

Fiscal Years	All Rehabilitants	Migratory Agricultural Workers and Seasonal Farmworkers
1973	360,726	265
1974	361,138	400 1/
1975	324,039	500 1/
1976	312,000 1/	600 1/
1977	33[illegible],000 1/	700 1/

1/ Estimated

Office of Child Development

The Indian and Migrant Program Division (IMPD) in the Office of Child Development funds grantees to provide comprehensive developmental services to migrant preschool children and their families.

Because of the unique needs of migrant farmworking families, programs had to be designed to provide the family with access to these resources without creating economic or other hardships. Resources alone, without an adequate system of delivery, will not solve the problems of migrant families with preschool children.

IMPD has developed and worked with several different program models during the past few years. Some of these models have proven to be less successful than others. IMPD's findings have shown that in any given area or region, a combination of program models is necessary to meet the existing needs.

All of the models used a basic program design which incorporates Head Start standards and quality child care services. This design calls for some structural modifications to the traditional Head Start program including: (1) extending the hours of operation to coincide with the parents' working hours; (2) allowing all preschool children to participate, including infants, and (3) utilizing bilingual and bicultural staff where needed. These modifications are necessary in order to provide the type of full service program which is tailored to the life style of migrant families.

Basically, there are two categories of program models, the Local Programs and the National Programs. Local Programs are Head Start programs which are funded to serve local communities, and which may also serve migrant children.

There are two National Program models; the Prime Grantee model and the Network model.

The Prime Grantee model approaches the need to extend the period of services by funding programs in user areas which had longer field work seasons and could operate in one location for four or five months. Families remaining in the area for the entire work season had access to a full service program and the children received educational benefits from having been enrolled for a sufficiently long period.

The prime grantee model also attempts to deal with the problem of program continuity. A referral system was devised to refer participants to Head Start programs operating in their home base areas. The child's medical and educational records are also to be transferred. The home base programs, however, are under no obligation to accept referrals and frequently the programs are filled by the time the child returns to the area.

The network model differs from the others in that it operates programs in both the home base areas and user states. The program operations follow the migrant streams during the seasons when field work is available and are located in established centers where large concentrations of migrants are found. As the families move from one area to the next the children can be enrolled at the next site. As the target population increases or decreases in a given area, staff members can be regrouped to accommodate the change.

IMPD will continue to refine these models and to develop other innovative approaches to guarantee that delivery systems of quality services are provided to the target population. In addition, IMPD recognizes the growing need for an increased effort in program development on behalf of migrants who are attempting to settle out and for seasonal farmworker families.

In addition, Head Start funds training and technical assistance projects providing direct assistance to Migrant Head Start programs. Other OCD funds are used to support child abuse and neglect and experimental and research projects.

	FY 1974 Actual	FY 1975 Actual	FY 1976 Estimate	FY 1977 Estimate
National Program Models....	$4,500,000	$5,600,000	$5,600,000	$5,600,000

OFFICE OF HUMAN DEVELOPMENT

MIGRANTS

Fiscal Year	1975	1976 Estimate	1977 Estimate
Rehabilitation Services Administration			
Basic State Grants..........	$1,020,000	$1,224,000	$1,440,000
Service Projects............	736,000	195,000	450,000
Subtotal, RSA......	$1,756,000	$1,419,000	$1,990,000
Office of Child Development			
Head Start..................	5,600,000	5,600,000	5,600,000
Total, Human Development....	7,356,000	7,019,000	7,590,000

PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Migrant Health

Migrant Health grants awards to plan, develop and operate projects to provide health care services to migrant agricultural laborers and seasonal farmworkers and their families in order to improve and maintain the level of their health relative to that of the general population. Services provided range from a full grouping of diagnostic, therapeutic, and follow-up medical services with provisions for dental care, disease screening and control, health counseling, preventive, referral, environmental, and outreach services to a more limited focus on infectious and specific diseases. Necessary hospital care and information on the availability and proper use of health services are offered as well as training persons to provide health services for migratory workers and their families.

During the current fiscal period (1976) the Migrant Health Program, administered by the Bureau of Community Health Services, HSA, DHEW, supports 105 migrant health projects.

A special demonstration program, designed to provide hospital care effectively and economically for a selected migrant population and to gather and evaluate data on hospital utilization and cost of hospital services, was initiated during fiscal year 1974 at a level of $3 million. The Bureau of Health Insurance, SSA, serves as the fiscal intermediary for reimbursing hospitals for care provided to eligible migrants in this demonstration. Twelve migrant health projects have initiated programs with 19 hospitals to provide access to inpatient care for approximately 80,000 migrants at a fixed daily rate.

Obligations or programs in migrant health

	1973	1974	1975	1976 Estimate	1977 Estimate
Health Services...	$22,223,000	$22,223,000	$22,824,000	$19,200,000	$19,200,000

MULTIPLE SCLEROSIS

Multiple sclerosis is a devasting chronic disorder affecting the brain and spinal cord, often producing severe muscle weakness and affecting vision and speech. Characterized by demyelination (destruction of the fatty sheath surrounding nerve fibers), multiple sclerosis attacks an estimated 250,000 Americans with an additional 250,000 suffering from other closely related demyelinating disorders. Although the course, severity and range of symptoms vary greatly among patients, multiple sclerosis often leads to complete disability. Tragically, patients are usually stricken during their most productive years, between the ages of 20 and 40. While to date there is no known cause or cure for this great crippler of young adults, the most promising research leads are in the areas of genetics, virology and immunology.

"... the time is now for a concerted, well-managed effort to unravel the mysteries of MS." So concluded the National Advisory Commission on Multiple Sclerosis, appointed by the DHEW Secretary in accordance with an act of Congress, in its February 1974 report to the Secretary, the Congress, and the President. "This is so," the Commission added, "not only because the sketchy prevalence data available indicate that this may be one of the greatest national health problems not receiving due attention, but because the Commission believes, there now are groups of dedicated laymen and informed scientists who are ready and determined to apply the necessary effort to develop practical means for control of the disease." Research conducted and supported by the NINCDS reflects this commitment.

Obligations for Programs in Multiple Sclerosis and Related Disorders

	1973	1974	1975	1976 Estimate	1977 Estimate
National Institutes of Health:					
National Institute of Neurological and Communicative Disorders and Stroke	$4,212,000	$4,770,000	$6,174,000	$6,347,000	$6,419,000
Office of Human Development: Rehabilitation Services Administration: Basic State Grants.....	589,000	650,000	680,000	680,000	720,000
Total............	4,801,000	5,420,000	6,854,000	7,027,000	7,139,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological and Communicative Disorders and Stroke

Multiple sclerosis (MS) is one of the most common, yet least understood chronic disorders affecting the nervous system. Although the demyelination at "multiple" sites in the central nervous system and the subsequent development of hard patches or plaques of "sclerosis" at these sites gives multiple sclerosis its name, scientists as yet do not know whether these events represent the cause of multiple sclerosis or the end manifestation or reflection of some underlying process.

The course of multiple sclerosis is totally unpredictable and different for each patient, which generally includes extensive and sometimes disabling muscular weakness, dizziness, and blurred vision. For symptoms appear episodically, in a varying rhythm of periods of exacerbations (recurrence and usually worsening of symptoms) and remissions (cessation of symptoms). While a majority of patients can expect to live up to 75 percent of their normal lifespan, those years can often be marred by frustrating incapacitation and dependency on their families, placing an enormous psychological and economic burden on all involved. And, in their later years, multiple sclerosis patients may experience other resultant distressing symptoms including partial or near-total blindness, kidney disease, and bladder incontinence. Although multiple sclerosis is rarely regarded as the direct cause of death, accompanying lung or bladder infections can be fatal.

The outlook can seem bleak since no causes or cures for multiple sclerosis have yet been found. However there have been some important research leads. One recently comes from studies this year which have confirmed earlier findings of a transmissible (viral) agent obtained from brain tissue of multiple sclerosis patients. Further studies should substantiate whether this agent is indeed responsible for the disease. In addition, striking new evidence indicates that the tendency to develop multiple sclerosis may be inherited, possibly through receipt of genes producing a defect in the body's immune (defense) system. The finding of a possible genetic predisposition to developing the disorder is the first real key in defining a multiple sclerosis-prone population, and seems to tie in closely with the intriguing viral and epidemiological (relationship of the factors determining the frequency and distribution of disease) clues surrounding multiple sclerosis which have been uncovered in the past several years.

Government support of multiple sclerosis research is primarily by the NINCDS. This past year this support was at the $7 million level. The National Multiple Sclerosis Society, a leading voluntary health agency, is now spending more than $4 million annually on research. Recent findings, coupled with the advanced new scientific technology which has made their discovery possible, are bearing out the conclusions of the National Advisory Commission on Multiple Sclerosis in its report to the President: "...there is good reason to believe that if intensified research is undertaken now it will yield, in the forseeable future, significant advances in its control and eventually practical means to prevent or arrest its further progress."

The Multiple Sclerosis Commission Recommendations

The nine-member Multiple Sclerosis Commission was appointed by the Secretary of Health, Education, and Welfare in accordance with Public Law 92-563, to conduct a year-long exhaustive evaluation of the status of multiple sclerosis research. The members, five scientist-physicians and four laymen, assisted by 53 specialists in highly relevant research areas, have proposed a number of recommendations for future research and many of these have already been incorporated into the Institute's program.

As suggested by the Commission and occasioned by important research leads, the NINCDS is greatly intensifying its multiple sclerosis research here at the NINCDS and at other institutions through approximately 57 grant and contract-supported projects. Vigorous emphasis is being placed on virological and immunological (defense system) studies; in addition to the two major NINCDS laboratories currently engaged in viral research, a new laboratory of neuro-immunology recently has been established, headed by a leading scientist in the field. This laboratory, which plans to pursue both basic and clinical research, will look into the way the body resists acute and chronic infection. Scientists will also be determining how genetic factors may influence the immune system and whether an autoimmune response (a misdirected attack by the body against itself) is involved in multiple sclerosis demyelination.

Interest in demyelination as a result of an autoimmune response is in part generated by an analogy with the animal disease, experimental allergic encephalomyelitis (EAE). As recommended by the Commission the Institute is continuing studies of this animal disease which produces demyelination and plaque formation, and under certain experimental conditions, a chronic relapsing course.

The Institute has also followed the Commission's recommendation to designate an Institute staff scientist as the focal point for NINCDS activities relating to multiple sclerosis. As one of his first undertakings, a comprehensive NINCDS-sponsored conference, "Perspectives in Multiple Sclerosis--1975" (hereafter referred to simply as "Perspectives"), was held in February 1975. Summaries of the presentations, representing the most up-to-date knowledge and thinking on multiple sclerosis were published in the May 1975 journal Neurology for the rapid dissemination to other researchers and clinicians in the field.

The Commission also recommended that five Clinical Research Centers be designated and funded. Prior to the Commission's report, two centers were funded by the Institute at UCLA and at the University of Pennsylvania in collaboration with the Wistar Institute. Since the report, two more Centers have been funded at Emory University, Atlanta, and at Albert Einstein College of Medicine, New York City. Additionally, a program project to study multiple sclerosis and amyotrophic lateral sclerosis has been awarded to the Scripps Foundation and Medical Center, La Jolla, California. These centers are providing a valuable interface between clinical and basic research.

Also in line with the Commission's recommendations, the Institute is seeking better methods of diagnosing and treating multiple sclerosis. These efforts may be enhanced by new immunological and virological findings which may have therapeutic applications.

Multiple Sclerosis Research

The most promising research to date centers around five main areas: immunological, epidemiological and virological factors, and diagnostic and treatment possibilities.

Genetics and Immunology

Significant evidence now suggests that multiple sclerosis patients may inherit a tendency to develop the disorder, possibly through receipt of genes producing a defective immune system. Studies by Drs. Casper Jersild and Bo Dupont and colleagues at the Memorial Sloan-Kettering Cancer Center in New York, and recently corroborated by other studies, have shown a substantially higher incidence of particular "histocompatability antigens" in multiple sclerosis patients as compared to the population at large. Histocompatability antigens are protein molecules which are present in cells of all individuals. However, types of histocompatability antigens differ among individuals, depending on the inherited genes which direct their production.

The New York scientists' studies of 1465 multiple sclerosis patients and 4238 controls from various parts of the world, showed a significant increase in the combined relative risk for multiple sclerosis among individuals having the histocompatability antigens "HL-A3" and "HL-A7." They found that 40 percent of multiple sclerosis patients had the HL-A7 antigen as opposed to 25 percent in the control population. Even more dramatically, they found a 60-70 percent prevalence of the histocompatability LD-7a (now referred to as DW-2) determinant in multiple sclerosis patients, as compared with 16 percent in normal individuals. There also appeared to be a correlation between the presence of this determinant and the rapidly progressing form of multiple sclerosis. Furthermore, they found that a large percentage of multiple sclerosis patients with the HL-A3 and 7 antigens, and their families, also had high levels of antibody (the body's first line of defense against an invader) to measles virus. This indicates that factors within the histocompatability system contribute to the control of antibody production.

Confirming this association between multiple sclerosis and the HL-A3 and 7 antigens among multiple sclerosis patients in the Boston area is a study by Dr. Barry Arnason of Massachusetts General Hospital. In addition, his review of data from 457 multiple sclerosis patients (studied by four independent groups in widely separated geographical areas) corroborated the findings of a significant alteration in the frequency of the HL-A3 antigen, and a highly significant association of this antigen with multiple sclerosis.

Epidemiology

This pattern of association between multiple sclerosis and histocompatability antigens also seems to follow the peculiar geographic distribution of multiple sclerosis. Epidemiological studies have demonstrated areas of high and low risk for multiple sclerosis. Generally, high risk areas are those north of the 40th parallel (latitude) including the northern United States, northern Europe and the Scandanavian countries, while southern U.S. and southern Europe are considered low risk. Significantly, Dr. Arnason's review of 457 multiple sclerosis patients also showed an increased frequency of the HL-A3 antigen among northern Europeans, where the incidence of multiple sclerosis is high, compared to the southern Europeans where the incidence is lower. Additionally, the HL-A3 antigen was found to be uncommon among the Japanese, where the incidence of multiple sclerosis is rare. Dr. David Poskanzer at Massachusetts General Hospital, Boston, is now engaged in an Institute contract studying environmental, genetic and infectious factors which may be influencing the abnormally high incidence of multiple sclerosis in the Shetland and Orkney Islands, where 250 per 100,000 persons have multiple sclerosis. All multiple sclerosis patients on the Islands have been identified, and they, their families and controls have been tested for histocompatability antigens. An analysis of the data is expected by the end of this fiscal year.

While epidemiological studies present multiple sclerosis patterns, hard data are needed on the actual number of multiple sclerosis victims, their degree of incapacitation, and on the cost of multiple sclerosis to them, their families and to the Nation in terms of lost wages. To answer these questions, the Institute has completed a contract pilot study and is preparing a report due to be released in February 1976. Every neurologist and neurosurgeon in the country along with other physicians sampled (such as family practitioners) is being asked to provide a list of patients diagnosed with multiple sclerosis. In addition, hospitals in 50 geographic sample areas are being asked to identify hospital patients with a multiple sclerosis diagnosis. This should provide the first comprehensive assessment on the prevalence of multiple sclerosis. From this population, a number of patients will be interviewed for a sample of the severity of disability and cost.

A final epidemiological factor, which has intrigued scientists for years, is that if persons move from an area of high risk for multiple sclerosis to one of low risk before the age of 15, their chances of developing multiple sclerosis become similar to that at their new residence. If they move after age 15, however, the high or low risk factor from their old environment stays with them. This may indicate that factors influencing multiple sclerosis are introduced before the age of 15. Therefore, migrant workers are currently being studied in the U.S., Netherlands, France, Great Britain, and Israel to determine which common factors are present or absent in the migrant workers' initial homeland. However, these studies may take on added significance in light of information on what are known as "slow" or latent viruses. These viruses, which have been shown by NINCDS scientists Drs. Carleton Gajdusek and Clarence J. Gibbs and colleagues to be the cause of other neurological diseases, remain dormant in the body for years before some triggering mechanism sparks them into action.

Viruses and Multiple Sclerosis

Three important findings initially influenced the search for a "multiple sclerosis virus." First, the fatal neurological disorder, subacute sclerosing panencephalitis (SSPE) was found to result from a "slow" infection by a virus, closely resembling if not identical to the measles virus; significantly, the SSPE patients always had elevated amounts in their cerebrospinal fluid of immunoglobulin G, an antibody against measles. The second finding is that many multiple sclerosis patients also have elevated levels of IgG. The third finding is that another slow virus "kuru" is confined to inhabitants of a small New Guinean area, possibly suggesting these people have an inherited inability to combat a particular slow virus.

The viral theory may be enhanced this year by the promising studies confirming earlier findings of a transmissible viral agent possibly associated with multiple sclerosis. In the earlier studies conducted by Dr. Richard I. Carp and colleagues from the New York State Institute for Basic Research in Mental Retardation, an agent found in brain tissue and serum from multiple sclerosis patients caused a decrease in the number of mouse white cells (which fight infection); and this effect could be passed into other mice injected with brain material from these mice. A similar phenomenon is seen with certain other viruses. Further studies showed that mouse cells innoculated with multiple sclerosis specimens showed poor growth; and this phenomenon could be passed onto other mice cells.

Research studies subsequently had failed to confirm these findings, but interest remained because the lack of results could be attributed to the intricate and complex procedures required to demonstrate the presence of a viral agent, to the exclusion of other extraneous factors which often alter results. Now a confirmation study on the decrease in mouse white cells published in December 1975 by Dr. Werner Henle and colleagues at the Philadelphia Children's Hospital has precipitated a new flurry of activity to further substantiate the transmissibility of the agent, which according to researchers is often present in the blood as well as brain tissue of multiple sclerosis patients. Studies are now aimed at duplicating the results and in determining whether the decrease in white cells is evidence enough of viral involvement, since other characteristics of classic viral infection are not produced. Therefore, if further investigations confirm the presence of such an agent, its role in multiple sclerosis will have to be demonstrated. If it proves to be the "multiple sclerosis virus" scientists then will attempt to identify it so that therapeutic measures can be developed.

If a virus is involved in multiple sclerosis, it may be a "slow" virus since symptoms usually do not emerge until the young adulthood years. Adding fuel to this theory are studies on what are referred to as "defective interfering (DI) particles." These are particles of virus, but unlike a complete virus, they are not infectious. Furthermore, these particles greatly slow down viral infection when together with a complete virus, they co-infect a normal cell.

By successfully competing against the complete virus for the invaded cell's resources, these particles cause a 10-fold reduction in the rate of replication of the complete virus. This could be the mechanism which allows only small amounts of virus to remain, causing a chronic slow infection which could take years to produce symptoms. Dr. Robert Lazzarini from NINCDS recently characterized these DI particles and isolated some new types. Dr. John Holland and colleagues at the Scripps Clinic and Foundation, La Jolla, isolated these DI particles (from the rabies virus) in animals, proving their existence in mammals. Now they have for the first time produced a chronic infection in animals by injecting a combination of complete virus and DI particles. This dramatic demonstration in animals has led to increased interest and activity on DI particles and their possible involvement in multiple sclerosis and in a number of other as yet unexplained disorders.

The excitement over whether DI particles may be involved in slowing down a viral infection to a chronic state in multiple sclerosis is heightened by the possibility that the inhibitory property of DI particles could have far-reaching therapeutic implications. For instance, it is possible that a "DI particles vaccine" could be developed to ward off the possibility of infection. Or, massive doses of DI particles could be injected after infection to completely inhibit viral replication.

Events at the cell membrane play an important role in slow viral infections. These events can now be seen through a brilliant laboratory technique called "freeze-fracture." NINCDS scientists Drs. Thomas Reese and Monique Dubois-Dalcq and colleagues are among the first in the country to apply this technique to the study of the nervous system. By freezing tissue, splitting it open and producing thin metal replicas of the fractured surface, a view is provided of the cell membrane proteins from every possible direction. The scientists currently are using this technique to study the SSPE measles virus at the cell membrane to gain a better understanding of its maturation.

Several studies have shown that certain events at the cell membrane, which produce a slowdown of viral replication, are characteristic of paramyxoviruses, the group to which the measles virus belongs. As reported at the "Perspectives" meeting by Dr. Purnell Choppin and colleagues from the Rockefeller University in New York, these events may center around certain proteins, called glycoproteins because they also contain carbohydrates. In the viral assembly process, these glycoproteins form spike-like projections on the virus surface while proteins without carbohydrates attach to the inner surface. Qualitative or quantitative changes in these proteins, or in their role in assembling the virus may be involved in the establishment of persistent infections. Their possible role in such infections therefore is a key question to be answered.

Work by NINCDS research chemists, Dr. Richard H. Quarles and colleagues has shown that in mammals there is a high molecular weight glycoprotein in myelin, the fatty sheath surrounding central nerve fibers which is destroyed in multiple sclerosis patients. Scientists believe glycoproteins may play a role in the immune or viral aspects of multiple sclerosis since glycoproteins account for a high proportion of the myelin surface, since they are known to be receptors for certain viruses, and finally since they are the first to be destroyed when myelin is challenged by a toxic agent.

Because of the strong implications of viral involvement in multiple sclerosis, numerous approaches to viral identification are being taken. If the newly confirmed evidence of a multiple sclerosis agent is substantiated, identifying the agent will become the focal point for the "multiple sclerosis virus." Intensive studies this year may have application to that agent, or may represent important leads in their own right.

At the various multiple sclerosis centers, scientists are continuing attempts to isolate and characterize infectious agents obtained from multiple sclerosis patients' tissue and from autopsied brains to determine if they have a direct relationship to multiple sclerosis.

At the Scripps Clinic and Research Foundation in La Jolla, contract studies under Dr. William Meinke are continuing on the complex and exciting method of viral identification through "hybridization." Genetic material, deoxyribonucleic acid (DNA), from a known virus is labeled with a radioactive tracer and mixed with DNA isolated from autopsy specimens of multiple sclerosis brain tissue. If the DNA from a known virus binds (hybridizes) with the DNA from multiple sclerosis brain tissue, it would identify DNA in that brain related to the known viral DNA.

Whether or not the measles virus is involved in multiple sclerosis remains at best inconclusive, with the main suggestive evidence centering around elevated levels of the antibody IgG in multiple sclerosis patients. Perhaps the most compelling indication of measles involvement to date comes from the Sloan-Kettering scientists' data. As Dr. Casper Jersild reported at the "Perspectives" meeting, multiple sclerosis patients with the HL-A3, 7 and LD-7a histocompatability antigens had increased levels of measles antibody in cerebrospinal fluid, and antibody against measles was high among the patients' family members. They further reported that leukocytes (white blood cells which fend off infection) from multiple sclerosis patients failed to react when challenged with measles, but did react when challenged with other bacterial and viral antigens. Leukocytes from normal participants on the other hand, did react to all the challengers. However, since only some preparations of measles virus showed this reactivity pattern additional research is needed to verify and extend the findings.

According to the scientists, this lack of reactivity with measles antigen may represent either a selective, specific immune deficiency of primary importance in susceptibility to multiple sclerosis, or it may represent a secondary phenomenon related to other abnormal immune functions. It is however, the rationale behind an experimental treatment for multiple sclerosis using what is known as "transfer factor" to reverse this lack of reactivity.

Treatment for Multiple Sclerosis

To date, there has been no effective treatment to cure multiple sclerosis. Currently, however, there are two--diametrically opposed--experimental approaches to therapy. One centers around transfer factor, based on the above mentioned failure of multiple sclerosis patients' white blood cells to effectively challenge measles virus in laboratory studies. It has been theorized that restoring cellular response against invaders in multiple sclerosis patients may prevent further exacerbation of the disease. Therefore, transfer factor (essentially white cells) from individuals who exhibit a high degree of cellular reactivity to measles antigen has been administered to multiple sclerosis patients. Dr. Torben Fog from Copenhagen, Denmark, and colleagues (including Drs. Casper Jersild and Bo Dupont) reported at the "Perspectives" meeting on their studies of 10 patients being given transfer factor for 1 to 2 years. These patients, who have a known progressive course of multiple sclerosis, will be evaluated to see if progression continues during transfer factor treatment. Although it will be another year before final results are obtained, initial results indicate that while there are no side effects, the ability of their leukocytes to react to a challenge of measles virus seems only temporarily reversed during treatment.

Meanwhile, scientists are watching closely a study on transfer factor treatment by Rockefeller University scientist, Dr. John B. Zabriskie and colleagues in New York. Three groups, each composed of 45 patients are participating in this double-blind study (neither scientist nor patient knows whether the patient is receiving transfer factor or a non-treatment placebo). Although it is too early to draw conclusions on therapeutic efficacy, results of their earlier studies have been encouraging. Those preliminary studies involved 16 patients who received transfer factor at one-week intervals and exhibited an increase in their cellular response to measles antigen. The increase was maintained for at least 6 weeks. Their current study, because it is double-blind, should eliminate any possible psychological factors which may influence results. This nonspecific increase in immune response seen with administration of transfer factor suggests that a certain decrease in cellular immunity against certain virus antigens may exist in multiple sclerosis patients.

The opposite approach to therapy centers on the possibility that multiple sclerosis patients may have exaggerated cellular immunity, and therefore might respond to treatment with the immunosuppressive agent, antilymphocyte globulin, combined with steroids. Two independent clinical studies were reported at the "Perspectives" meeting, one by scientists from the Institute for Surgical Research in Munich under Professor W. Brendel and one by Dr. Eugene M. Lance of Honolulu. Both studies involved only a small number of patients (13 and 14 respectively) and both reported that a majority of patients showed significant clinical improvement. In the Honolulu study clinical appraisal was based on a four-point evaluation of sensory and motor modalities, balance, speech and vision. The Honolulu investigators reported that although a number of minor but undesirable side effects occurred, (primarily from steroid use) patients had a significant reduction in relapse rate compared with the number predicted on the basis of their experience before treatment. The relative success of these preliminary studies justifies further investigation. Although results from these two experimental protocols are still in the preliminary stages, the Institute is encouraging well designed therapeutic studies using these or similar approaches.

In addition to seeking a curative treatment, research is also focusing on treating multiple sclerosis symptoms. One of the most distressing is spasticity, the involuntary and often painful muscle spasms. Spasticity can be mitigated, in many instances (provided treatment is begun in its early stages), by using antispasmodic drugs combined with physical therapy to preserve remaining muscle strength and mobility. In addition, a system for electrically stimulating muscle contraction to build up weak muscles may become available. Ohio Case Western Reserve scientists, Dr. Thomas Mortimer and colleagues, under contract from the NINCDS Neural Prosthesis Program, are testing such a system for generating movement in limbs of spinal cord injury patients. Although still in the experimental stage, the device may be perfected for use not only in spinal cord patients but also in multiple sclerosis patients.

Another problem shared by spinal cord injury patients and many persons with multiple sclerosis is incontinence. This often requires catheterization which can carry the risk of fatal bladder infection. Experimental studies in animals by neural prosthesis contractor Dr. Emil Tanagho and colleagues at the University of California, San Francisco, have provided preliminary evidence that artificial control of bladder function may also become possible. Their animal studies show that it may be possible to simultaneously stimulate contraction of muscles in the bladder wall while relaxing exit sphincters, thus simulating the natural urinary process.

Diagnosis of Multiple Sclerosis

Because the disease can be so devastating and the treatment so limited, the lack of absolute diagnostic techniques is a major problem. Many physicians are hesitant to make the diagnosis of multiple sclerosis if there is a possibility that the patient may instead have a less serious, transitory disorder. Scientists are searching for more accurate diagnostic methods. Elevated IgG antibody has consistently been one such marker, although studies by University of Vermont researcher Dr. Charles Poser indicate that one of the building blocks of IgG and other proteins, an amino acid called "serine," may actually be a more sensitive marker. The scientists found elevations in serine occurred in 82 percent of multiple sclerosis patients tested, while elevations of IgG were found in only

50 percent of patients. He also found that patients with higher amounts of serine had generally more multiple sclerosis activity. Now determining the presence of the multiple sclerosis-related histocompatibility antigens may prove to be an even more useful diagnostic tool.

Another diagnostic aid may come from studies conducted by NINCDS scientist Dr. Henry deF. Webster and colleagues who are studying demyelinating activity in transparent tadpoles. Using this new model system, they have demonstrated, through direct observation, that cerebrospinal fluid and serum from multiple sclerosis patients produces destruction of the tadpole's optic nerve. More sensitive investigations aimed at establishing whether this observation is specific for multiple sclerosis are being pursued.

Another potentially important aid in diagnosis and determining cellular progression of multiple sclerosis may be the newly developed brain scanner manufactured by an English firm, EMI Limited. This combines computer and X-ray techniques to distinguish extremely small differences in the densities of tissues deep in the brain. With refinements, it may become possible through this technique to reveal areas of demyelination and their extent and progression. These and similar scanners are available at a number of medical centers, and the Institute along with the National Cancer Institute and Clinical Center, has purchased one which is being used clinically at NIH. NINCDS has also purchased one for use in basic neurological studies. However, none of the diagnostic techniques are incontrovertible and research is continuing on finding methods for a definite diagnosis. Ultimately, it is hoped and anticipated that research will provide answers to the cause and cure for multiple sclerosis, so that a patient diagnosed as having the disorder will no longer have to fear the implications.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

MULTIPLE SCLEROSIS

Because of the nature of the disease, sometimes rapidly progressive and sometimes relatively quiescent for a period of years, multiple sclerosis has been a challenging problem for workers in the field of vocational rehabilitation. Estimating ultimate employment potential is extremely difficult; and the State-Federal program of vocational rehabilitation has had limited success in serving this disability group.

The Rehabilitation Services Administration entered into a Cooperative Agreement with the National Multiple Sclerosis Society in October 1968 for the purpose of expanding and intensifying services for the victims of multiple sclerosis. It was expected that increased coordination between State rehabilitation agencies and local chapters of the Multiple Sclerosis Society would result from this Cooperative Agreement, with the concomitant development of case finding, improvement of service techniques, and expansion of vocational opportunities for the multiple sclerotic.

The Rehabilitation Services Administration has issued a special Medical Bulletin on Multiple Sclerosis to provide the State rehabilitation agencies with current information on this disease, and to stimulate these agencies to increased efforts in rehabilitation of the multiple sclerotic, with greater use of the special program of evaluation services for a period of up to eighteen months as authorized by the Rehabilitation Act being recommended as a helpful resource. The Medical Bulletin cites a study of some 1,300 people with multiple sclerosis which shows that: 70% were able to work within the first 5 years after onset; 50% within 10 years; and that 35% were still gainfully employed between 15 and 20 years after onset.

With further advances in drug therapy, neurosurgical procedures, and rehabilitation techniques, the rehabilitation potential of those suffering with multiple sclerosis should be greater than at present. Since the larger proportion of persons with multiple sclerosis are women in the 20 to 40 age group, one objective should be to accept increasing numbers for services with the vocational goal of homemaker.

The Research and Training Centers supported by the Rehabilitation Services Administration are conducting research on ways through which the handicapping effect of multiple sclerosis can be better understood so that it can be counteracted or minimized. Four medically-oriented Research and Training Centers are conducting studies on the electrophysiological mechanisms in neuromuscular diseases such as multiple sclerosis, on quantitative and qualitative evaluation in diseases of the central nervous system, and on the histochemistry of human muscle spindles.

Number of Rehabilitations with Multiple Sclerosis

Fiscal Years	Persons Rehabilitated	
	Total	Multiple Sclerosis
1973	360,726	499
1974	361,138	500
1975	324,039	450
1976	334,200 1/	460
1977	353,000 1/	475

1/ Estimate

MUSCULAR DYSTROPHY AND THE NEUROMUSCULAR DISORDERS

The neuromuscular disorders, characterized generally by weakness, wasting, and fatigue of the muscles, generally claim children and young adults as their victims. Some of the neuromuscular diseases cause rapid death and some cause chronic paralysis and invalidism. The two most common disorders in this group, the muscular dystrophies and myasthenia gravis, afflict some 200,000 and 100,000 patients respectively. When other less prevalent neuromuscular disorders are included, estimates of the number of patients with these conditions range from 300,000 to as many as one million.

The Department's research activities in muscular dystrophy and other neuromuscular disorders are centered in the National Institute of Neurological and Communicative Disorders and Stroke of the National Institutes of Health; its rehabilitation activities are the responsibility of the Rehabilitation Services Administration of the Social and Rehabilitation Service.

Obligations for Programs in Muscular Dystrophy and Other Neuromuscular Disorders

	1973	1974	1975	1976 Estimate	1977 Estimate
National Institutes of Health					
National Institute of Neurological and Communicative Disorders and Stroke...	$5,841,000	$6,722,000	$8,587,000	$8,648,000	$8,903,000
Office of Human Development:					
Rehabilitation Services Administration:					
Basic State Grants Section 110..........	589,000	650,000	816,000	816,000	792,000
Total...........	6,430,000	7,372,000	9,403,000	9,464,000	9,695,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological and Communicative Disorders and Stroke

At the National Institutes of Health in Bethesda, Maryland, clinical studies on muscular dystrophy, myasthenia gravis, and other neuromuscular disorders are centered in the National Institute of Neurological and Communicative Disorders and Stroke's (NINCDS) intramural Medical Neurology Branch. Multidisciplinary research is aimed at chosen target disorders, evolving basic research techniques and applying them to clinical neurological problems.

The NINCDS also supports some 124 research grant projects related directly to neuromuscular disease in hospitals, medical schools, and universities. There is a collaborative PL-480 research program in neuromuscular disease with the Warsaw Medical Academy, Poland, and Columbia University, New York. A collaborative program on neuromuscular diseases with Hopital Salpetriere and INSERM, Paris, is being developed, and a formal understanding of collaboration with the Weizmann Institute, Israel, has been made.

The Institute works closely with the Muscular Dystrophy Association, Inc. (MDA), and the Myasthenia Gravis Foundation. These two voluntary health agencies also support research in related neuromuscular disorders. This year the MDA has allocated over $7 million for research on these crippling disorders, matching the funding by the NINCDS in this area.

MUSCULAR DYSTROPHY

The Problem

The muscular dystrophies are a group of chronic, inherited disorders characterized by progressive weakening and wasting of the skeletal or voluntary muscles. Most types of muscular dystrophy are inherited, but any may occur spontaneously in a family as the result of a mutation or a new genetic change.

As the disease progresses, a patient may become confined to a wheelchair or have difficulty performing the ordinary activities of living. A common cause of death in these patients is respiratory failure which results from infection. Heart failure also is found in some patients.

There are three principal types of muscular dystrophy. Duchenne muscular dystrophy, which is probably the most common type, affects male children almost exclusively and appears between two to six years of age. Since it is a sex-linked, recessively inherited disorder, a woman who is a carrier of the trait has one chance in two that each male child born to her will be affected, and one in two that each female child will be a carrier like herself.

The first symptoms in Duchenne are a waddling gait and difficulty in climbing stairs or in rising from the floor due to pelvic girdle muscle weakness. Later, shoulder girdle muscles become affected. The disorder progresses without remission until death occurs, usually within 10 to 15 years, although some patients live considerably longer.

A second type of muscular dystrophy, facio-scapulo-humeral muscular dystrophy, affects the muscles of the face and shoulders. It can be transmitted as a dominant trait. That is, if either parent carries the gene for this type of muscular dystrophy, each child born, male or female, has a 50 percent probability of being affected.

A third type, limb-girdle muscular dystrophy, affects the muscles of both the pelvis and shoulders. When both parents are carriers of the defective gene, each of their offspring has a 25 percent chance of inheriting the disorder and a 50 percent chance of being a carrier. Limb-girdle muscular dystrophy strikes between the first and third decade of life and its progress is sometimes rapid.

Variant types also exist. Myotonic muscular dystrophy is an autosomal (not sex-linked) dominant disease beginning in young adulthood and characterized at first by stiffness in the limbs and inability to relax the handgrip, and later progressing to severe disability from muscle weakness and wasting. It also affects several other body tissues, including the heart, the lens of the eye, the testicles, and the brain.

Muscular dystrophy of late onset becomes noticeable in the fourth or fifth decade and affects both sexes. The first sign of the disease is weakness of muscles of the pelvic girdle. Its course is variable.

Diagnosis

Accurate diagnosis of the specific type of muscular dystrophy is vital since patients with other closely related neuromuscular diseases that simulate muscular dystrophy can be treated successfully, even though there is no treatment yet for any type of muscular dystrophy. In addition, accurate diagnosis facilitates evaluation of any treatment and aids the physician in his efforts to counsel the patient and his family.

The Muscular Dystrophy Association, Inc., through a nationwide network of 155 clinics, offers differential diagnosis free to anyone suspected by his physician to be suffering from muscular dystrophy or related neuromuscular disorders.

Sophisticated methods developed through research are providing scientists with increasingly more detailed knowledge of the various muscular dystrophies and are leading to improved diagnosis. Diagnosis is usually based on the combination of clinical examination, family history, microscopic examination of muscle samples (biopsies), electromyography (recording of the muscle's electrical activity), and determination of levels of creatine phosphokinase (CPK), the enzyme that leaks out of damaged muscle tissue into the blood.

NINCDS scientists this year developed a new, rapid and simple method of quantitating active skeletal muscle damage in experimental animals using the radioactive tracer Technetium 99m (99mTc) labeled diphosphonate. The method has been expanded to clinical studies and can identify muscle damage in several muscle disorders, including Duchenne muscular dystrophy and dermatomyositis.

The investigators were able to show good correlation between the uptake of the tracer and body levels of other chemical indicators conventionally used in diagnosing these disorders. Unlike the conventional techniques which require considerable processing of tissue, the new procedure requires only an intravenous injection of tracer and measurement of radioactive concentrations in the tissue samples with a scintillation counter.

Muscle biopsy has proven valuable both as a diagnostic technique and as a research method to learn about muscle fibers in their normal and diseased states. Normal human muscle fibers are of two basic types--Type I and Type II fibers--which usually are evenly distributed.

NINCDS scientists have found that in myotonic dystrophy (a hereditary muscle disorder of young adulthood), there is a reduction in the size of Type I fibers and an increase in the size of Type II fibers. This change is relatively specific for myotonic dystrophy. They also found that in hypokalemic periodic paralysis (a disorder of the young characterized by attacks of weakness) there were no alterations in the Type I fibers, but Type II fibers showed atrophy in approximately half the cases.

This year NINCDS scientists in collaboration with investigators at New York University School of Medicine through histochemistry identified two distinct Type I fiber subtypes. The subtypes were shown to be selectively involved in two different neuromuscular disorders, indicating that subtyping may prove informative in evaluating the pathological processes in certain neuromuscular diseases and in diagnosing these disorders.

Diagnosis of certain muscle disorders is made almost exclusively by muscle biopsy because clinical signs are nonspecific. Accurate diagnosis of these disorders is important since their course can vary dramatically.

Open-biopsy electromyography, reported on last year as the first technique to permit the correlation of electrical activity with chemical analysis (histochemistry) of muscle fibers, continues to provide important diagnostic information. With this procedure, developed by NINCDS scientists, the electromyography apparatus is brought into the operating room, the electrical activity of the muscle fiber is recorded, and the muscle tissue sample is excised and prepared for histochemical study.

NINCDS scientists have achieved a breakthrough with the development of special electrodes that allow experimental recording of nerve and muscle electrical activity during free movement. The new electrodes will permit the study of active muscles, in contrast to previous conventional techniques which are suitable only for studying muscles at rest.

An additional test for diagnosing the muscular dystrophies and differentiating them from other neuromuscular diseases, including polymyositis, was reported recently by a group of Japanese investigators from the Kobe University School of Medicine. They found significant rises in CPK activity in patients with muscular dystrophy following administration of the steroid prednisolone. No such increase was observed in other muscular disorders.

Preliminary evaluation of a simple test to diagnose Duchenne muscular dystrophy in newborns has been very promising. The procedure, developed by NINCDS grantees at the University of Iowa, measures creatine phosphokinase in a drop of dried blood and appears to be significantly more effective than standard CPK measurements. If this test is found to be as accurate as the early results indicate, it could be extremely valuable as an aid in counseling the carrier mother in her later pregnancies. However, as long as no definitive treatment exists, a postnatal diagnostic test is of much less value than a test applicable early in pregnancy. The search for a suitable test of this type continues.

Treatment

No real cure is known for any of the muscular dystrophies. Antibiotics to control infections, however, have lengthened life in many patients, and physical therapy has increased the mobility of these patients and has enabled them to lead more active lives.

Of the many drugs tested for therapeutic use in muscular dystrophy, none has been able to retard or reverse the progression of the muscle weakening. Important nonspecific treatment includes physical therapy which may delay the shortening of the muscles; use of braces, walkers, special shoes, and corsets to compensate for muscle weakness; certain surgical procedures on muscles; special schooling, and special summer camps for afflicted children.

Preliminary studies by researchers at Downstate Medical Center, New York, indicate that they have succeeded in arresting in tissue-cultured dystrophic chick embryo cells the disease process characteristic of muscular dystrophy. It is the first time that an exogenous agent has demonstrated effectiveness in slowing the degeneration of dystrophic muscle cells.

Working on the hypothesis that certain enzymes (proteinases) which normally digest intracellular protein may, in the higher concentrations found in muscular dystrophy, actually digest the muscle fibers (protein) themselves, the researchers sought to inhibit these enzymes hoping to delay the degenerative process. The results have been encouraging, and indicate that the proteinase inhibitors might eventually be used in clinical trials with humans.

Duchenne muscular dystrophy, because of its hereditary nature, is most successfully prevented by detecting female carriers of the Duchenne muscular dystrophy gene and then providing genetic counseling before they bear children. It is now possible to determine fetal sex by sampling the pregnant woman's amniotic fluid and studying the chromosomes in the harvested cells. If the unborn child is a male, a mother who knows she is a carrier can be alerted, and given an opportunity to decide if she wishes to terminate the pregnancy.

Research to Identify Carriers

Significant research advances in recent years have simplified detection of carriers of Duchenne and have reduced the number of unidentified carriers. An even more precise detection system may be possible through the recent finding by NINCDS grantees of abnormal muscle protein synthesis in Duchenne patients and carriers. The investigators already have successfully monitored carriers in several large families using the new procedure.

In preliminary studies conducted by NINCDS supported scientists at Pittsburgh, the levels of an enzyme in the serum called Pyruvate kinase (PK) were found to be 50 percent higher than CPK values in 29 carriers of Duchenne muscular dystrophy. The observation that the PK test is significantly more sensitive than the CPK test might be important in attaining a higher detection rate of Duchenne carriers. A broad screening study is required to support these provocative results.

Other methods of detecting carriers of Duchenne and other forms of muscular dystrophy are being explored. NINCDS scientists, for example, have found that muscle samples taken from carriers of Duchenne muscular dystrophy show degeneration and regeneration of scattered grouped muscle fibers.

Abnormal structural changes in the muscle fiber of Duchenne carriers may provide additional clues for identification of these individuals. Electron microscopic observations of fibers supported diagnosis by other methods and identified cases in which no other laboratory evidence was yet available.

Search for Underlying Cause

Historically, the causes of the various forms of muscular dystrophy have been looked for in the muscle itself. However, failure to find the seat of the disease in the muscle has led some investigators to look elsewhere. Today scientists are looking for the cause not only within the muscle cell, but also in its surface membranes, in the nerve which innervates the muscle, and in the muscle's blood supply system.

In the past few years, NINCDS investigators have introduced a new hypothesis for the cause of Duchenne muscular dystrophy. They believe that muscle damage may be produced by abnormalities of the small (arterial) blood vessels within the muscles rather than by a defect in the muscle itself. They further postulate that such blood vessel abnormalities may become apparent only when certain blood vessel constricting agents are present.

The scientists also have reported pharmacological evidence to support their hypothesis. They were able to reproduce in rats the early and midstage characteristics of the disease both by tying off blood vessels and using vasoactive drugs (serotonin or noradrenaline) to constrict the vessels. Neither procedure alone, however, caused changes in the muscle fibers. They also found that following administration of the vasoactive drug the serum muscle enzymes rise, as in Duchenne muscular dystrophy. These scientists now are using this test to screen for drugs that might be effective in preventing reduction of blood in the muscle. They recently demonstrated the effectiveness of three drugs (imipramine, phenoxybenzamine, chlorpromazine) in preventing muscle damage when given before the blood supply is restricted by the drug. These drugs, therefore, may be possible therapeutic agents for ischemic muscle disease in humans.

NINCDS supported scientists from Duke University Medical School recently found evidence of a biochemical functional abnormality in the muscle and red blood cell membranes in Duchenne patients. These findings which were similar to their earlier observations in myotonic muscular dystrophy indicate that both Duchenne and myotonic dystrophy are inherited disorders of membranes with widespread tissue involvement.

NIH supported researchers at the University of Connecticut School of Medicine, studying muscle, liver, and red blood cell membranes in dystrophic chicks, have found evidence of functional and biochemical abnormalities in membranes of these animals. It is still not clear what relation animal dystrophies have to human dystrophies but clues may be provided to human disorders.

Last year evidence of a neuronal abnormality in a form of dystrophy seen in mice was reported by a British research team. They found that dystrophic muscle behaves normally when regenerating in culture in the presence of normal spinal cord tissues, but is abnormal when coupled with spinal cord samples from dystrophic mice. Recently, however, NINCDS grantees from Albert Einstein College of Medicine showed that normal and dystrophic muscle can regenerate equally well in the presence of fetal spinal cord obtained from either normal or dystrophic mice. They tentatively conclude that the primary lesion in muscular dystrophy is probably at the site of the muscle rather than the nerve.

A new technique for growing human skeletal muscle without neural influence in tissue culture has been developed by NINCDS scientists in collaboration with investigators at New York University Medical Center. Tissue cultures provide unique opportunities for evaluation of growing muscle fibers without neural, vascular, and other influences that are operating in the patient. The observation of whether structural and chemical changes present in the patient's biopsied muscle fibers will or will not be reproducible in a tissue culture environment could help in explaining the progress of a given disease.

Another potentially important abnormality noted in Duchenne muscle is concerned with the sarcoplasmic reticulum, the vesicles intimately related to muscle contraction through their capacity to accumulate and release calcium within the muscle cell.

In addition to biochemical evidence presented by NINCDS grantees at the University of Pittsburgh of abnormal calcium uptake by the sarcoplasmic reticulum (SR) of Duchenne patients, NINCDS scientists recently demonstrated increased calcium in the SR and a second structure (mitochondria) within damaged muscle cells at the electron microscopic level. The NINCDS scientists propose that the surface membrane of the SR breaks down, allowing calcium to accumulate in the structure.

A team of Scottish scientists have developed a computerized method for analyzing the electrical output of muscle fibers and have used the technique to evaluate muscular dystrophy. Their results support the presence of a neurogenic influence on the muscular dystrophies.

While many scientists have thought for a long time that myotonic dystrophy is essentially a disease of the muscle fiber, NINCDS researchers are continuing to gather evidence that the muscle weakness and atrophy are caused by an abnormal of the motor nerve to the muscle rather than the muscle itself. This hypothesis, developed as part of the large effort by NINCDS to differentiate between primary disorders of nerves and intrinsic muscle disorders, may redirect some of the research to uncover the precise cause of myotonic dystrophy and related disorders

MYASTHENIA GRAVIS

Myasthenia gravis is a chronic neuromuscular disease characterized by progressive weakness and abnormally rapid fatigue of the voluntary muscles, with improvement following rest. The disorder generally appears between ages 15 to 35 years in females, and ages 40 to 70 in males.

Over the past two decades research advances have produced significant reductions in the death rate and degree of illness in myasthenia gravis patients, even in the most severe cases. Improvements in support systems, such as intensiv hospital care, respirators, and antibiotics, and widespread use of tracheostomy (surgery to open the windpipe) undoubtedly have contributed to the welfare of the myasthenia gravis patient. But the most dramatic advances have centered on the development of certain drugs that facilitate the transmission of nerve impulses across the nerve-muscle junction for muscle activation. In myasthenia gravis, transmission of this nerve-to-muscle impulse is defective in some way.

Formerly many myasthenia gravis patients died within the first few years of their illness. Today, scientists believe the majority of patients will live out a normal lifespan. Many patients cooperating with their physicians can expect to lead virtually normal lives.

The highlight of the past year's research programs on myasthenia gravis centers on new findings relating to the cause of the disease. Yet, as scientists continue to zero in on the cause, and therapy remains directed toward symptoms, myasthenia gravis is one of the most successfully managed neuromuscular disorders

Theories on Cause

The cause of myasthenia gravis remains unknown, but scientists agree that the problem exists somewhere along the motor unit, which consists of the lower motor neuron (a branching nerve fiber), and the muscle fiber it activates. Recent research studies have focused on the neuromuscular junction--the point at which the motor nerve endings transmit their signals to the muscle fibers.

Normally a substance called acetylcholine is released from the nerve ending and crosses a gap or synapse to a muscle region called the end plate. There the acetylcholine attaches to certain protein molecules on the end plate known as receptors and triggers muscle contraction. In myasthenia gravis this mechanism is impaired.

This year NINCDS supported researchers produced dramatic evidence that myasthenia gravis is an autoimmune disorder in which the victim's own body sets up an immune reaction against itself.

Drs. Jim Patrick and Jon Lindstrom of the Salk Institute in La Jolla, California, were able to induce myasthenia-like weakness in rabbits by immunizing the animals with acetylcholine receptor (AChR) protein purified from the electric organ of the eel.

The antibodies raised in the rabbits to ward off the foreign electric eel AChR protein reacted with the animal's own receptor protein and produced progressive weakness similar to that observed in myasthenia gravis. Also, the muscle end plates of the affected rabbits resembled those of a myasthenia victim.

These results, which have been confirmed in several other laboratories and have been extended to other animal species, represent a promising new approach for studying the mechanisms involved in the cause and cure of myasthenia gravis.

The animal model already has generated an intensive search for an immunologic cause of myasthenia gravis.

A team of researchers at Israel's Weizmann Institute of Science has found that a mixture of proteins from normal muscle were attacked in the test tube by lymphocytes (the white blood cells that attack invading germs) from myasthenia patients. Investigators at the Massachusetts General Hospital in Boston have shown that the lymphocytes seem to be specifically targeted on the receptors. Lymphocytes taken from myasthenics attacked and destroyed purified receptor extracts.

The earlier observation that infants of mothers with myasthenia gravis sometimes have a transient form of the disease has led scientists to suspect the presence of a circulating abnormal substance in the serum of myasthenic patients.

At the NIH campus NINCDS scientists utilizing a new molecular probe have shown that sera from a majority of patients with myasthenia gravis contain an immunoglobulin (probably an antibody) that binds to the receptor. The investigators believe that this is likely to be the circulating factor causing the weakness in myasthenia gravis.

Corroborative evidence of a circulating serum factor comes from a preliminary report by NINCDS supported scientists at The Johns Hopkins University School of Medicine. They successfully produced myasthenic characteristics in mice by injecting them repeatedly over a 10-day period with material from blood serum of myasthenia gravis victims.

These immunologic clues offer great hope that the mystery of myasthenia gravis will be unravelled and a more effective weapon against this disease will be developed.

A new method for accurately identifying skeletal muscle fibers that have lost normally accompanying nerve fibers has been developed by NINCDS scientists. This technique is directly applicable to investigating the influence of partially or completely interrupted motor neurons on muscle fibers in myasthenia gravis and offers a new approach to the study of neuromuscular diseases. By injecting a radioactive compound in the spinal fluid and spinal cord, they have found the compound is taken up by the motor nerve cells and is converted into a specific protein. The protein flows down the motor nerve and accumulates at the nerve-muscle junction. This is the first step to demonstrate that protein crosses to the muscle to serve as a nutrient factor.

Advances in Diagnosis

Diagnosis of severe myasthenia gravis usually can be made without difficulty on the basis of history and physical examination alone. Myasthenia gravis may affect any voluntary muscle, but usually involves those of the eyes, face, lips, tongue, throat, and neck more severely than others. Involvement of muscles of breathing and limb movement also can be severe.

Symptoms may vary depending upon which muscles are affected. The disease may begin with a localized weakness, or as a severe generalized weakness. A patient may experience difficulties in breathing, swallowing, or talking, or have double vision, or arm or leg weakness. There may be unusually rapid muscle fatigue following repetition of a movement.

Confirmation of the diagnosis is achieved with drug studies as well as electrical, mechanical, and X-ray tests. Injection of a drug that facilitates nerve-muscle message transmission may result in a dramatic increase in strength. Administration of a neuromuscular blocking agent that inhibits the transmission of nerve-muscle messages causes increased weakness. Responses to these agents usually confirm the diagnosis of myasthenia gravis. Repetitive electrical stimulation of the nerve-muscle apparatus provides objective evidence of impaired transmission.

NINCDS scientists have developed a new diagnostic test involving the intravenous infusion of a lactate compound. Injection of this compound has produced significant decreases in various voluntary muscle functions, including respiration, voice, grip, and movements of eyelids in a series of patients. The investigators conclude that this appears to be a reliable and specific test and is somewhat safer than the generally used curare test for evoking the myasthenic weakness.

The NINCDS grantees at the Salk Institute in California who developed an experimental autoimmune myasthenia gravis animal model also recently developed a method for analyzing the immunologic response against receptor protein in the sera of myasthenia gravis patients. Their method shows promise for development into a routine diagnostic test for myasthenia gravis and as a measure of the progress of immunosuppressive therapy.

Study of the thymus (a gland-like organ in the chest that normally atrophies with increasing age) is often valuable. If there is diagnosis of tumor of the thymus in myasthenia gravis patients, this will have important bearing on both the treatment and outcome of the disease. Moreover, the role of the thymus in causing the disease is of increasing research interest.

Advances in Treatment

Basic research on the transmission of nerve impulses for muscle activation has produced an increasingly precise picture of this mechanism and has led to refinement in treatment. Several drugs provide relief from symptoms, and others may be effective against one or another cause. For nearly 40 years the anticholinesterases, especially pyridostigmine and neostigmine, have been mainstays of symptomatic treatment.

Prednisone Therapy. NINCDS scientists continue efforts to expand on their development of a new treatment--a high, single dose, alternate-day, oral prednisone regimen--which has proven extremely beneficial over long periods in the majority of patients tested. Prednisone is a synthetic drug that acts similarly to the natural hormone, cortisone. Patients over age 40, especially males, appear to respond best to this treatment. Physicians throughout the world have confirmed the beneficial results. In fact, NINCDS scientists now consider alternate-day prednisone the most effective treatment and believe it may suppress the disease sufficiently long for it to disappear.

Although Institute scientists last year demonstrated in animal nerve-muscle preparation an adverse interaction between corticosteroid and anticholinesterase drugs, they now find that low doses of one can be combined with the other advantageously. They recommend, however, that patients receiving such treatment should be watched carefully.

ACTH Therapy. There is substantial documentation that treatment with ACTH (adrenocorticotrophic hormone) benefits severely ill patients. One of the disadvantages of this therapy earlier found by NINCDS grantees was that many receiving a 10-day course of daily ACTH experienced temporary muscle weakness and increased difficulty in breathing for the first several days before improvement began to appear. Paradoxically, the patients who experienced the greater initial weakness usually showed the more striking eventual recovery. Continued maintenance ACTH injections every few days or weekly recently were found to prolong the beneficial effects. NINCDS grantees also have found that short intensive courses of ACTH are useful in improving temporary weakness.

Thymectomy. Thymectomy (surgical removal of the thymus) was found by NINCDS supported scientists to be beneficial in nearly 90 percent of a large patient series, most of whom were severely affected. These data plus the positive results from several additional studies have convinced some scientists that thymectomy should be performed routinely on all myasthenia gravis patients, especially younger females.

New Agents. A group of drugs known as the germine acetates are being evaluated for their effectiveness in managing myasthenia gravis. An early report noted that patients treated for a short time exhibited improved neuromuscular function. Other investigators have reported favorable results from use of germine monoacetate (GMA) for outpatients over a limited time.

POLYMYOSITIS/DERMATOMYOSITIS

Two muscle diseases, quite similar to muscular dystrophy and sometimes misdiagnosed as muscular dystrophy now are treatable. Polymyositis and dermatomyositis are inflammatory disorders of the muscle and skin, characterized by elevated muscle enzymes, such as creatine phosphokinase (CPK), circulating in the serum. These disorders, if left untreated, often are steadily progressive and fatal.

The method of treatment introduced by NINCDS scientists (long-term, high, single dose, alternate-day prednisone) continues to be the single best available treatment for children and adult patients. In some patients who do not respond to corticosteroid therapy, Institute scientists have found that addition of azathioprine, an immunosuppressant drug, produces beneficial results. Those scientists are now conducting trials to more clearly establish the efficacy of azathioprine. A team of German scientists also using azathioprine to manage polymyositis patients recently found the agent to be beneficial in certain cases.

NINCDS scientists are able now to demonstrate, by the study of lymphocytes (a variety of white blood corpuscles) in these patients, the degree to which lymphocyte function is controlled or inhibited by the drugs. A distinct "on-day" "off-day" effect has been demonstrated showing a pattern of inhibition of lymphocytic function during the "on-day" of prednisone with a gradual increase during the "off-day" when prednisone is not given. This is a basic test which now can be used to compare patients who are responding and who are not responding to prednisone.

Evidence of an immune reaction causing vascular injury in dermatomyositis of childhood, which earlier was reported by NINCDS scientists, has now been confirmed by others.

HYPOKALEMIC PERIODIC PARALYSIS

NINCDS scientists have demonstrated dramatic improvement for as long as 9 years in patients with hypokalemic periodic paralysis who were treated with acetazolamide. The disorder is characterized by attacks of paralysis, usually beginning in childhood or adolescence, at daily to yearly intervals.

MYOPHOSPHORYLASE DEFICIENCY

NINCDS investigators recently confirmed an earlier study in which they were able to provoke production of the enzyme myophosphorylase in the muscle fibers of patients suffering from myophosphorylase deficiency. The "revival" of this enzyme which is essential in sugar metabolism occurred when the muscle cells were regenerating after injury. This development was a surprise since it had generally been considered to be genetically absent. It is now hoped that therapeutic efforts can be directed toward promoting production and retention of myophosphorylase in mature fibers. Conceivably this approach could apply to other genetic enzyme deficiencies as well.

ACID MALTASE DEFICIENCY

This year NINCDS scientists working with New York University investigators were able to reproduce (in cultured tissue) enzymatic and structural defects characteristically found in acid maltase deficiency. This demonstration of a muscle biochemical defect represents a system of potential use in evaluating methods of preventing muscle fiber damage in the disease.

DISCOVERY OF NEW DISEASES

Since the report two years ago of a rare new myopathy--carnitine deficiency--by NINCDS grantee investigators in Minnesota, several new cases have been discovered. Carnitine, a component of muscle tissue, was found to be absent in the skeletal muscle of patients with progressive muscle weakness. The scientists believe they have uncovered a second type of carnitine deficiency disorder which can mimic primary liver disease. Prednisone therapy has been shown to improve the patients' weaknesses. The reason for the carnitine deficiency is not known.

NINCDS scientists have described a new disorder, levitated arm syndrome, in which repeated injections of drugs into the muscle can produce muscle degeneration. This disorder which can be misdiagnosed as muscular dystrophy, can be prevented by stopping the injections in the muscle. Even if the disorder has progressed to the point where the arms are stuck in an upwardly fixed position, it can be treated successfully with surgery.

NINCDS scientists, in collaboration with investigators at the National Cancer Institute, recently uncovered in a family of patients an entirely new mechanism for a hereditary sensory neuropathy never before seen. A sensory neuropathy is a disturbance of the peripheral nervous system, characterized by lightning pains and loss of cutaneous sensation. The patients were found to have an elevated production of an immunoglobulin protein (IgA) in their intestinal tract. The investigators hypothesize that a local infection in the intestinal tract, which occurs through hereditary predisposition, actually causes the neuropathy--perhaps by preventing absorption of the proper substances from the food or by manufacturing toxic substances. Whatever the mechanism, this finding raises the interesting possibility of a link between the intestinal tract and the actual neuropathy in this hereditary disease.

Spinocerebellar ataxias represent a broad group of diseases characteristized by failure of muscular coordination. In two families with one of these diseases, called Friedreich's ataxia, NINCDS scientists recently found evidence of a genetic disorder involving a defect in a metabolic function. Although this finding does not provide the cause of the spinocerebellar degeneration characteristic of the disease, it does give researchers a new biochemical approach to the actual metabolic defect damaging the nervous system.

OFFICE OF HUMAN DEVELOPMENT

Rehabilitation Services Administration

MUSCULAR DYSTROPHY

Because of the nature of the disease, victims of muscular dystrophy have limited potential for gainful employment, and therefore only a small number of them have been rehabilitated through the State-Federal program of vocational rehabilitation. It is hoped, however, that the acquisition of new medical knowledge concerning this disabling condition will contribute to positive gains over the next decade in the work capacity of the muscular dystrophy case. State vocational rehabilitation agencies will be serving increased numbers of persons disabled by muscular dystrophy due to the emphasis in the Rehabilitation Act of 1973 on serving the severely disabled.

Research activities in the Rehabilitation Research and Training Centers address the diminished or total loss of muscular function and the complications that accompany the disease. Examples of this type of research include a study of lung expansion in patients with muscular dystrophy, a study of the structure and ultrastructure of the muscles in neuromuscular diseases such as muscular dystrophy, the effects of submaximal exercise in strengthening the muscles in muscular dystrophy, and the effects of hormonal agents in muscular dystrophy. With the discovery of new knowledge and the development of techniques and procedures that will improve muscle function and treatment of muscular dystrophy, more patients afflicted with the disease can be vocationally rehabilitated.

Rehabilitations With Muscular Dystrophy

Fiscal Years	Persons Rehabilitated Total	 Muscular Dystrophy
1973	360,726	328
1974	361,138	400
1975	324,029	400
1976	334,200	400
1977	353,000	400

*Data FY '74 on are estimates.

NURSING HOMES

Obligation for Programs in Nursing Homes

(In Thousands of Dollars)

	1973	1974	1975	1976 Approp.	1977 Estimate
Office of Assistant Secretary for Health [1]					
Office of Nursing Home Affairs...............	---	---	443	578	700
ADAMHA					
National Institute of Mental Health...........	7	100	32	182	25
Health Resources Admin.					
BHPRD, Division of Facilities Development.[2]...	3,561	8,669	4,445	7,000	3,000
Bureau of Health Manpower.[3]	---	---	849	---	---
National Center for Health Statistics..........	769	329	671	690	695
National Center for Health Services Research.[4]	5,396	5,322	4,266	2,139	2,655
Health Services Admin.					
Bureau of Quality Assurance..................	---	---	---	240	190
Office of the Secretary					
Regional Directors.........	---	---	4,828	5,792	6,679
Facilities Engineering and Property Management........	---	---	560	722	731
Administration on Aging....	---	---	---	1,201	not available
Social and Rehabilitation Service					
Skilled Nursing Facilities...............	---	---	1,198	1,346	1,607
Intermediate Care Facilities...............	---	---	1,137	1,338	1,438
Social Security Admin......	---	---	6,494	6,546	6,623
Total..................	9,733	14,420	24,923	27,774	24,343

[1] Does not include funds spent by other PHS Agencies for special projects or staff costs (four positions charged to HRA).

[2] Does not include chronic disease hospitals or long-term care units of hospitals (see material on activities for aging).

3/ $605,278 were obligated for long-term care facilities personnel of convalescent homes and rehabilitation centers.

4/ Includes program management costs associated with the Division of Long-Term Care (639,000 per year).

OFFICE OF ASSISTANT SECRETARY FOR HEALTH

Office of Nursing Home Affairs

The Office of Nursing Home Affairs was formed as the Departmental and Public Health Service focal point for nursing home affairs called for by the President's Nursing Home Directives of August 1971. On August 30, 1974, a revised Statement of Organization, Functions and Delegations of Authority was issued giving ONHA responsibility to serve as the focal point for long-term care (LTC) and for Office of Assistant Secretary for Health's (OASH) responsibilities in Departmental programs on aging. In 1975 further responsibility was delegated to ONHA for coordinating the development of a comprehensive interagency objective to expand both beneficiaries and services covered by home health care.

In addition to being broadly involved and working closely with PHS and Departmental agencies in the Headquarters area, ONHA works directly with the Regional Offices of Long Term Care Standards Enforcement (OLTCSE) in all of the Regional Offices to advise and administer the activities relating both to the approval and termination of agreements with skilled nursing facilities (SNFs) participating in Medicare and Medicaid programs.

To assure a free flow of information and communication among all of the involved agencies, an Intra-agency Long term Care Advisory Group meets regularly to report on assigned tasks and recommends priority action area.

Currently involved in aspects of long term care and aging are: the Bureau of Health Insurance of the Social Security Administration; Medical Services Administration of Social and Rehabilitation Service; Bureau of Quality Assurance, Health Services Administration; National Center for Health Statistics; Comprehensive Health Planning Service, Health Care Facilities Service (Hill-Burton), and the Bureau of Health Services Research, all of Health Resources Administration; National Institute of Mental Health, Alcohol Drug Abuse, and Mental Health Administration; National Institutes of Health; Administration on Aging; and Office of Facilities Engineering and Property Management.

Major program areas in which the Office of Nursing Home Affairs is involved include.

A. Long Term Care Facility Improvement Campaign (LTCFIC)

On June 21, 1974, the Department of Health, Education, and Welfare announced a campaign to improve long-term patient care in nursing homes. The initial projects of this campaign was a survey of skilled nursing facilities. This survey was conducted under the lead of ONHA in coordination with the Office of the Under Secretary. The survey asked three basic questions: Who are the patients? How are nursing homes managed? How good is patient care? The survey was conducted by teams of specially trained experts. Each team consisted of a physician, a nurse, an administrator, a nutritionist, a pharmacist, a physical therapist, a fire safety engineer, and a social worker. The initial data gathering phases of the LTCFIC was completed during November 1974. A complete report of the survey findings entitled LONG TERM CARE FACILITY IMPROVEMENT CAMPAIGN: INTRODUCTORY REPORT was published in July 1975. Several clear needs for action emerged from the survey findings. These needs include:

1) A total review of the survey/certification process.

2) Nationwide training and certification of all State surveyors.

3) Complete analysis of the entire fiscal approach to reimbursement for services provided.

4) Alternatives to institutional care, such as home health care and day care.

B. Development of Standards for Long Term Care

Uniform Federal regulations governing participation of skilled nursing facilities in Titles XVIII and XIX were published in January 1974 and additional standards requiring medical direction, seven-day registered nurse coverage, discharge planning, and patient's bill of rights were published in October 1974. In 1974, a revised definition of skilled level of care was published. Interpretive guidelines for professional and consumer groups as well as instructional guidelines for [illegible] for surveyors have been developed and implemented and are undergoing a constant process of review and revision to assure that the standards are being applied uniformly and consistently nationwide.

In order to maintain uniformity of standards for skilled nursing facilities, the Department is currently developing a procedure whereby skilled nursing facilities participating only in Title XIX may appeal from a denial of a waiver by the ROLTCSE of a requirement or requirements of the Life Safety Code.

In January 1974, the regulations governing intermediate care facilities (ICFs) were published, creating in response to Congressional legislation, a new level of care to be provided under the Medicaid program.

Guidelines and survey forms were developed for ICFs including special forms for needs of intermediate care facilities for the mentally retarded (ICF-MR) and developmentally disabled. Bureau of Quality Assurance, which has a lead role in interagency work groups developing guidelines and forms, projects training needs which new regulations will require and plans expanded activities to sensitize and alert surveyors to special needs of MR patients and facilities and upgrade technical assistance to providers.

Operations manuals for Regional and State officials were developed and distributed for SNF, ICF and ICF-MR programs and are being reviewed and revised as necessary to reflect programmatic policy and regulation changes on a continuing basis.

The regulations governing ICF-MRs provide that by March 1977, ICF-MRs must meet certain standards for the care of the mentally regarded although they may be certified under the general ICF standards for participation in the Title XIX program prior to that date providing they have submitted a plan of compliance the time they are certified as a general ICF showing that they will meet these standards in March 1977. Action is underway to assist the States through the ROLTCSEs in fulfilling their plans of compliance so that they will meet the ICF-MR standards.

C. Standards Enforcement

Cooperative efforts of Federal and State agencies are providing mechanisms for uncovering areas of abuse. One such cooperative effort is a program of unannounced visits to SNFs and ICFs for the purpose of assuring continued high quality care in our nation's nursing homes. Under this program, all Federal validation surveys are conducted totally unannounced to the facility. States are also encouraged to conduct unannounced visits on a sample basis and a majority of States have endorsed this concept.

Efforts to improve the enforcement of Life Safety Code requirements in SNFs and ICFs have been continued. This was done by providing additional training to State surveyors at the Regional Office level and by increased surveillance and review of State survey agency activities. Preliminary data for calendar year 1975 indicates that the participation agreements with 134 skilled nursing facilities were not renewed because of Life Safety Code deficiencies.

To insure greater uniformity in interpreting Life Safety Code requirements, the Department has established a Codes and Technical Standards Committee under the Office of Facilities Engineering and Property Management. The responsibility of this committee is to provide recommendations for interpreting the highly technical requirements of the Life Safety Code.

D. Long-Term Care - Management Information System

Demands for instant information on surveys, certification, status of individual homes, Life Safety Code inspections, termination of Federal funding, and other matters of current nursing home concern have now mounted to the point where it is imperative to produce up-to-the-minute answers without delay.

Several of the data programs developed or being developed within the Department contain information about long-term care facilities and needs. These include the National Center for Health Statistics' Nursing Home Survey, the Bureau of Health Insurance of the Social Security Administration's Health Insurance data and the Medical Services Administration of the Social and Rehabilitation Service's Management data. These data are being consolidated to develop a more consistent data base at both Headquarters and Regional levels. The Long-Term Care Management Information System (LTC-MIS) will be fully operational in FY 1977 and will provide a comprehensive data base for use by both headquarters and regional office staff.

E. Non-Institutional Care

There are many indications that home health and related programs are a cost-effective and humane ingredient in the continum of care, providing alternative and appropriate care and, at the same time, releasing valuable institutional resources to treat patients with more complex health care requirements. A two-pronged approach has addressed (a) the development and support of program activities related to the organization, management, and expansion of quality home health services; and (b) the promotion of greater utilization of home health services by resolution of problems of reimbursement in regard to Medicare and Medicaid recipients.

In January 1975, the Secretary delegated responsibility to the PHS to coordinate and monitor home health care activities and program development for the Department. Subsequently, this coordinating and monitoring function was delegated to Office of Nursing Home Affairs.

F. Consumer/Provider Interest in Nursing Home Conditions and Federal Standards

The Office of Nursing Home Affairs program of consumer/provider activities has included local, State, area-wide, regional and national levels of participation. The consumer comprised three major groups: (1) providers of services within the nursing home industry (i.e., industrial representatives and professional and non-professional personnel); (2) clients as consumers of services who seek or use these health care services (i.e., patients, families and additional community membership); and (3) other interested individual and group citizenry. The consumer groups were represented in terms of individual institutions and through national organizations or associations.

A series of Provider/Consumer meetings have been held which were designed to bring to approximately 100 key national organizations, and they to their constituency, an interpretation of Federal regulations or policy issues. The May 15, 1975, meeting highlighted important findings that resulted from the Long-Term Care Facility Improvement Study. The Secretary, DHEW delivered the opening remarks. The October 1975 meeting introduced the concept of patient assessment and its present and future implications for assisting consumers/providers in determining individual patient needs and for developing an appropriate plan of care. Future meetings will be based, on joint planning and exploration of mutual areas of concern from which consumer inputs will be obtained in designing policy issuances and program plans. Consumer/Provider meetings are held on a regular basis every six months.

Obligations
(in thousands)

	1973	1974	1975	1976	1977
Office of Nursing Home Affairs	-	-	443	578	700

NATIONAL INSTITUTE OF MENTAL HEALTH

NURSING HOMES

NIMH cooperates with other Federal agencies in the concern for the quality of the care provided for patients in long-term care institutions. Staff have been active in the rewriting of the standards for skilled nursing and intermediate care facilities. Through cooperative efforts with SRS, consultation and training programs for personnel working in nursing homes were developed. The document, "It Can't Be Home," published by NIMH for this purpose in 1973, has proven popular and useful in this regard. It has since been reissued and a training guide was developed which could be utilized in script writing for film production. Assistance was provided to the Bureau of Quality Assurance in the formulation of regulations and guidelines for a "Bill of Rights" for residents of intermediate care facilities and skilled nursing facilities.

During the current year, NIMH (1) revised and published "Make Each Person Count - A Guide for Nursing Home Personnel"; (2) reviewed and made recommendations on the Bureau of Quality Assistance (BQA) programmed syllabus for training of a state Medicare surveyor on rights of patients in skilled nursing facilities; (3) assisted BQA in an Interagency Work Group, in the planning of a conference relating to the Federal role in regulations and standards for hospitals, intermediate care facilities and skilled nursing facilities; (4) participated in the Utah Department of Mental Hygiene co-sponsored conference with Utah Nursing Home Association at Salt Lake City, Utah. The Conference focussed upon the collaboration of the Utah Department of Mental/Community Mental Health Centers with intermediate care facilities and skilled nursing facilities.

Further plans for the current year include a conference to articulate goals, principles and terminology which can serve as a base for development of community support systems for adults with seriously disabling mental or emotional disorders. In addition, a contract has been awarded for a study which will identify specific aspects of existing and proposed Federal legislation which have positive or negative impact on development of optimal support systems in States and communities. The project, to be completed April 30, will identify a range of specific legislative or regulatory changes which appear to be needed. Late in the spring, NIMH has plans for a conference to review the policy recommendations of the latter study, and to consider steps toward implementation of those recommendations considered to require action. Work also is underway toward preparation of a monograph which will describe promising approaches and models of community-based care for mentally disabled adults, and which thus provide alternatives to mental hospital or nursing home care.

In 1977, NIMH plans to retrospectively collect and analyze data on the transfer of over 65 year old patients to State mental hospitals to skilled nursing facilities and intermediate care facilities since the enactment of Medicare legislation.

There is also plans to develop a mongraph for use by nursing home personnel in administration of drugs (particularly psychotropic drugs) to aged residents.

HEALTH RESOURCES ADMINISTRATION

Bureau of Health Planning and Resources Development
Division of Facilities Development
Nursing Home Planning and Construction

Nursing homes have been an important element in health facility planning since the early years of the Hill-Burton program. From the mid 1950's until the signing of P.L. 93-641 in January 1975, nursing homes were assisted either under a separate appropriation category or under the "long-term care" category. As of November 1, 1975, almost 41,400 nursing home beds had been modernized or constructed with Hill-Burton assistance. Not included are similar facilities-hospital long-term care units, or chronic disease hospitals. State agencies report that 354,000 long-term care beds need to be modernized or added.

P.L. 93-641, signed on January 4, 1975, extended and extensively revised the Hill-Burton program. Nursing homes will no longer be aided under a separate long-term care formula grant category. However, they will be eligible under two types of formula grant assistance: (1) modernization of health facilities, and (2) construction of new inpatient medical facilities in areas which have experienced recent rapid population growth. The same facilities are also eligible for loans or loan guarantees with interest subsidy. A third type of grant assistance is project grants for construction and modernization projects designed to prevent or eliminate safety hazards in publicly owned medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards. The FY 1976 Appropriation contains $16.3 million for project grants, $57.9 million for formula grants (25 percent or more must be used for outpatient facilities), and nothing for new loan authority.

Bureau of Health Manpower

Nursing Homes

Contracts are awarded to develop, administer and evaluate pertinent courses for the training of long-term care personnel, including administrators and pharmacists working in nursing or convalescent homes and rehabilitation centers.

National Center for Health Statistics

The National Center for Health Statistics produces baseline and trend data on nursing homes, their services, operating expenses, residents and staff through biennial national nursing home surveys. The initial survey was conducted in 1973-1974, from a national sample of 2,100 nursing homes with a subsample of 25,000 staff and 20,000 current residents. Provisional data from that survey was published in September 1974. Reports presenting final data are now in preparation and are expected to be published this fiscal year.

The pilot study and pretest for the second survey are currently in progress. The pilot and pretest include three new data collection efforts: collection of data on discharged residents, longitudinal studies of changes in residents' health status, and changes in facility characteristics. Pretest objectives are to evaluate the feasibility of these data collection efforts for the national survey.

The national survey is scheduled for the fall and winter of 1976, with provisional data released in the spring of 1977. Review and analysis of data will begin at that time and continue until the fall of 1978.

Once survey analysis is completed, data tapes will be made available for general release to the public. National data on costs and characteristics of nursing homes, their residents and staff are needed on a continuing basis by a variety of data users for research and planning, providing and assessing long-term care services and facilities at State and local levels. It is expected that data from the nursing home surveys will influence legislation on standards for nursing homes, on reimbursement mechanisms, and on areas of coverage for national health insurance.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

The Research and Development Branch, Division of Long-Term Care, National Center for Health Services Research, continues to engage in research activities that relate to nursing homes as well as to alternative forms of health services in long-term care. The specific areas of concentration with direct applicability to nursing homes include development of systems of patient assessment to upgrade the quality of the care being rendered through improved placement decisions, patient care planning and regulatory surveillance; a cost data reporting system based on a set of uniform cost elements that relate service and patient characteristics to cost; a method of studying the outcomes of nursing home care (length of institutional stay, mortality rate, place to which discharged, change in functional status, change in mental status, and consumer satisfaction) as they relate to such variables as staffing patterns, costs, employee and administrator attitudes, environmental and structural variables and ownership-control status, and models of medical direction in skilled nursing facilities.

Responsibility for directing Federal resources toward short-term training of personnel employed in long-term care facilities continues in the Division of Long-Term Care. The National Center, however, no longer has legislative authority for short-term training and therefore, funds to support provider training activities have been provided by the Bureau of Health Manpower.

Since the inception of provider training activities with the Administration's Nursing Home Initiatives of 1971, there has been continual growth of training opportunities through a variety of strategies. The number of training opportunities supported has reached 100,000 professional and para-professional long-term health care personnel as of December 31, 1975.

In 1975, to further the Department's efforts toward upgrading the quality of care in the Nation's nursing homes by improving the skills of those responsible for providing that care, 25 training contracts were awarded or continued including: eleven new contracts in areas not previously addressed; for example, patient education, multidisciplinary training in drug therapy (American Pharmaceutical Association), administrator training (American College of Nursing Home Administrators), restorative nursing (Association of State and Territorial Health Officials), and one additional Regional Long-Term Care Education Center (Region IV); fourteen contracts for continuation of previously supported training efforts, including eight of the Regional Long-Term Care Education Centers, four state-wide aide training projects, and medical director training. Contracts to develop the LTC Media Center and the audiovisual aids were completed in 1975 and the final products are now available to the field.

HEALTH SERVICES ADMINISTRATION

Bureau of Quality Assurance

MEDICAL CARE STANDARDS

The Conditions of Participation for Skilled Nursing Facilities and Intermediate Care Facilities, and interpretive quidelines for use by State agencies and providers, and Conditions for Coverage of Services of Independent Laboratories were revised and issued in 1974. The revised regulations for skilled nursing facilities include special provisions for upgrading the quality of medical direction in these facilities, for improving discharge planning, and for safequarding and ensuring patients' rights. Similar efforts were made to revise and update, in 1975, the Conditions of Participation for Hospitals. Experimentation and developmental activities are currently underway in the area of standards to ensure the quality of services provided in ambulatory health care centers. The Division has also directed attention to the problems of fire safety in long-term facilities and, under contract with the American Nursing Home Association, is conducting a study ("Nursing Home Burn-out Sutdy," involving onsite burn-out testing) that should lead to the identification of needed modifications to the Life Safety Code of the National Fire Protection Association. As the Department's operational focal point for the interagency coordination of such efforts, the Division has worked in close collaboration with other health agencies in the Department, with the Office of Nursing Home Affairs, the Bureau of Health Insurance, SSA, and with the Medical Services Administration, SRS. Training and enforcement activities related to these efforts have continued, and new initiatives have been made along several fronts in the area of training, with Division headquarters and regional office staff of BHI and MSA.

The Division has participated in several ongoing programs designed to promote and maintain the quality of care provided to elderly persons. For example, the Division has provided support to the Bureau of Health Insurance and Medical Services Administration regional office staff in the conduct of comprehensive program reviews of State Medicare agencies; these reviews are a means of assessing the effectiveness of program policy and guidelines and the manner in which these are administered in the States. Through the provision of consultative and technical assistance, and other support activities, the Division has been involved in and has continued to promote quality assurance mechanisms.

Another ongoing comprehensive program instituted in 1970 was to improve the interpretation and uniform application of Federal health care programs by State agency personnel through training and evaluation of individual surveyor performance. This program was developed to meet specific need following the enactment of Medicare and Medicaid, and has been supported by the States, the Social Security Administration, and the Social and Rehabilitation Service, all of which have assisted in its development. The health facility surveyors have a major responsibility for ensuring that long-term care facilities, hospitals, and home health agencies, and other providers and suppliers of service, provide safe and adequate care and comply with required standards in serving Medicare and Medicaid beneficiaries.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The Professional Standards Review Organization Program was authorized by the 1972 amendments to the Social Security Act. This provision requires the Secretary to establish and support a nationwide network of voluntary, non-profit groups of local physicians to regulate the quality of health care services paid for under Medicare, Medicaid, and Maternal and Child Health Programs. The purpose of the statute is to improve the quality of health care services and to make more cost effective the expenditures for health care services financed by Titles XVIII, XIX, and V of the Social Security Act. PSROs are to accomplish these purposes by applying sophisticated concepts of peer review through a system of voluntary local organizations, State Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

PSROs will review the medical necessity of services, the quality of care delivered, and the appropriateness of the care in terms of the level, duration, and methods of treatment. In reviewing medical necessity and quality, PSROs will be determining whether health care services provided are necessary on the basis of professionally developed standards of norms of care, diagnosis, and treatment. In reviewing appropriateness, PSROs must determine whether the level at which health care services are provided (e.g., inpatient, outpatient, intermediate care) is the most efficient as well as the most effective level. This peer review system will assure that payment is made from Federal and State funds for only medically necessary, appropriate, and quality care.

Initially, PSROs will place emphasis on the review of institutional services, especially those provided in the acute general hospital. Eventually, the scope of their review will be expanded to encompass all facets of the health delivery system.

The PSRO program relates closely to and must be integrated with other health care review activities required by the Social Security Act particularly as the Act was amended in 1972. The PSRO legislation intends that utilization review, and other duplicative review activities will eventually be eliminated and PSROs will assume responsibility for such activities.

In 1974 the country was divided into 203 PSRO areas designated by the Secretary of DHEW. By the end of FY 1976 it is expected that there will be 65 conditional PSROs.

The 63 conditional PSROs funded in prior years and the two funded early in FY 1976 began operation of their review systems in short-term general hospitals. The hospital peer review system that these PSROs are using is an integrated one, which includes concurrent review, medical care evaluation studies and profile analysis.

PSRO activities during 1977 will focus on the following major objectives: continuation of the conditional PSROs; converting an additional 55 to conditional status, and funding up to 10 Statewide Councils; funding 83 new planning PSROs in order to cover all 203 PSRO areas; implementation of all regulations issued during 1976; and coordination of the END-Stage Renal Disease (ESRD) and PSRO programs. About 120 conditional PSROs will be in existence by the end of 1977, and some of these will initiate review in long-term care facilities.

Another important objective relates to the evaluation of the impact of the PSRO program on the quality and utilization of health care services financed under Medicare, Medicaid, and Maternal and Child Health programs.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OS-DEPARTMENTAL MANAGEMENT
Nursing Home Activities

Regional Directors

The Offices of Long-Term Care Standards Enforcement operates under the line authority of the Regional Directors. The function was organized in 1975 to consolidate survey and certification functions which had been separately administered by the Social Security Administration, Social and Rehabilitation Service, and Public Health Service. The objective of the Long-Term Care office is to insure that recipients of long-term care, whose costs are reimbursed by Medicare or Medicaid, receive quality care in a safe environment according to standards established by Federal laws and regulations. This objective is achieved in three ways: review and evaluation of State surveys of skilled nursing and intermediate care facilities; conduct of direct Federal validation surveys; technical assistance and training for State personnel, nursing home operators and employees and public interest groups.

Facilities Engineering and Property Management

The Long-Term Care Standards Enforcement Engineers located in the regional offices enforce life safety code regulations in Skilled Nursing Facilities, Intermediate Care Facilities and hospitals receiving payments under Medicare and/or Medicaid. These offices determine compliance with the provisions of the Life Safety Code of the National Fire Protection Association or other suitable State standards.

The Nursing Home Ombudsman Program
Administration on Aging

In July of 1975 Nursing Home Ombudsman Programs were initiated in forty-seven States, Puerto Rico and the District of Columbia for the purpose of protecting the dignity of elderly institutionalized citizens and promoting a high quality of care and life in residential care facilities. The immediate goal of the State programs is to develop an ombudsman process at the area or community level which will be responsive to complaints from residents or relatives of older persons in Skilled Nursing Facilities and Intermediate Care Facilities.

Background

The nationwide program has its roots in the seven Nursing Home Ombudsman Demonstration Projects, which were the first national demonstration of health-related ombudsman activities in this country. The demonstrations were developed in response to former President Nixon's 1971 Eight-Point Nursing Home Initiatives, in which the President directed the Department of Health, Education, and Welfare "to assist the States in establishing investigative units which would respond in a responsible and constructive way to complaints made by or on behalf of individual nursing home patients."

An inter-departmental work group was formed under the direction of the Health Services and Mental Health Administration to develop models for investigative/ombudsman units; and in the Supplemental Appropriations Act of December, 1971, Congress made available funds for the establishment of nursing home ombudsman demonstration projects.

In the Spring of 1972 letters were sent to the Governors of all fifty States, the District of Columbia, and national associations representing older persons inviting them to submit proposals for establishing nursing home ombudsman offices which would:

- become informed of the conditions under which nursing home patients live;
- take appropriate action to resolve problems in the area of long term care;
- receive, respond to and work to resolve complaints made by or on behalf of nursing home patients.

On June 30, 1972, five contracts were awarded by the Health Services and Mental Health Administration. Four were with State Governments to establish a State-level office linked to a local unit. The States were Idaho, Pennsylvania, South Carolina and Wisconsin. A fifth contract was awarded to the National Council of Senior Citizens to test the effectiveness of a nursing home ombudsman project that is operating independent of government jurisdiction and the feasibility of linking a national voluntary organization to State and local units. The National Council selected Michigan as the site of their demonstration.

Additional projects were started in Massachusetts and Oregon in July of 1973, increasing the total number to seven projects.

In 1973 the Health Services and Mental Health Administration was reorganized, and the Nursing Home Ombudsman Program was transferred to the Administration on Aging. Assignment of the program to AoA was consonant with the Commissioner on Aging's responsibility for serving as an advocate for older persons.

The Nursing Home Interests Staff of the Administration on Aging assumed responsibility for administration of the projects during the third and final year of funding as demonstration models.

Development of the Nationwide Program

In May of 1975 the Commissioner on Aging invited all State Agencies on Aging to submit proposals for grants to enable the State Agencies to promote effective ombudsman activiites at the State level and to develop the capabilities of the Area Agencies on Aging to promote, coordinate, monitor and assess nursing home ombudsman activities within their service areas.

States which submitted proposals were funded in July of 1975 under the authority of Title III, Section 308 of the Older Americans Act. The $1,112,604 available for the Nursing Home Ombudsman Program was offered to the States on a population formula basis. Grants are for one year from the date the program commenced in each State. A list of the States and amount awarded is attached.

State agency personnel and staff employed under the grant were provided orientation/training in bi-regional meetings held in San Francisco, Chicago, Philadelphia and Atlanta from October 14 through November 6, 1975. Content for these sessions included:

1) Discussion of the purpose and goals of the program by the Commissioner on Aging;
2) A review of aging network at the Federal, State and Area levels;
3) Discussion of nursing home ombudsman functions and techniques and how the lessons from the demonstrations could be applied by the new Ombudsman Developmental Specialists;
4) An introduction to the long term care system provided by staff of Regional Offices of Long Term Care Standards Enforcement and regional staffs of the Public Health Service, Bureau of Health Insurance, and Medical Services Administration;
5) A presentation by staff of the Senior Citizens Law Center and National Council of Senior Citizens Legal Research and Services for the Elderly Project on how legal services could be utilized by ombudsman program personnel and what legal resources are available.

As of January, 1976, Ombudsman Developmental Specialists have been designated in forty States.

The role of State and Area Agencies on Aging in developing the program is discussed in the AoA January 13, 1976 Technical Assistance Memorandum 76-24.

NURSING HOME OMBUDSMAN PROGRAM GRANTS

Alabama	$18,000	Missouri	$18,000
Alaska	18,000	Montana	18,000
Arizona	18,000	Nevada	18,000
Arkansas	18,000	New Hampshire	18,000
California	54,708	New Jersey	21,285
Colorado	18,000	New Mexico	18,000
Connecticut	18,000	New York	57,931
Delaware	18,000	North Carolina	18,000
District of Columbia	18,000	North Dakota	18,000
Florida	30,608	Ohio	29,574
Georgia	18,000	Oregon	18,000
Hawaii	18,000	Pennsylvania	38,188
Idaho	18,000	Rhode Island	18,000
Illinois	32,493	South Carolina	18,000
Indiana	18,000	South Dakota	18,000
Iowa	18,000	Tennessee	18,000
Kansas	18,000	Texas	30,810
Kentucky	18,000	Utah	18,000
Louisiana	18,000	Vermont	18,000
Maine	18,000	Virginia	18,000
Maryland	18,000	Washington	18,000
Massachusetts	18,385	West Virginia	18,000
Michigan	22,702	Wisconsin	18,000
Minnesota	18,000	Puerto Rico	18,000
Mississippi	18,000		

TOTAL $1,046,784

The following additional grants were made to the original Ombudsman Demonstration Projects to enable them to provide leadership for the new programs and to demonstrate ways in which ombudsman projects could utilize legal services. The figures are:

Massachusetts	$45,000
Idaho	30,000
South Carolina	26,943
Wisconsin	30,000
Michigan	22,560
TOTAL	$154,503

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPORT ON ACTIVITIES IN

Aging

A REPORT TO THE

HOUSE COMMITTEE ON APPROPRIATIONS

FEBRUARY, 1976

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ACTIVITIES SERVING OLDER AMERICANS

FISCAL YEAR 1975

In response to the many social, health, economic, education, and other needs of the Nation's elderly, a wide range of programs serving this age group were administered during 1975 by various agencies throughout the Department of Health, Education, and Welfare. This report begins with a tabular summary of actual and expected yearly expenditures for activities on behalf of older Americans of each HEW agency which administers one or more major programs serving this segment of the population. This is followed by narrative descriptions, in the following order, of these activities:

I. Office of Human Development
   - A. Administration on Aging
   - B. Rehabilitation Services Administration
   - C. Office of Native American Programs
   - D. Office of Rural Development

II. Social Security Administration

III. Public Health Service
   - A. Health Services Administration
   - B. National Institutes of Health
   - C. Alcohol, Drug Abuse, and Mental Health Administration
   - D. Health Resources Administration

IV. Social and Rehabilitation Service
   - A. Assistance Payments Administration
   - B. Public Services Administration
   - C. Medical Services Administration
   - D. Office of Planning, Research, and Evaluation

V. Office of Education

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging
(in thousands of dollars)

I. Office of Human Development	1973 Actual	1974 Actual	1975 Actual	1976 [1] Estimate	1977 [1] Estimate
A. Administration on Aging					
Title III, Area Planning and Social Service Programs	68,000	68,000	82,000	76,000	82,000
Title III, Planning, Coordination, Evaluation, and Administration of State Plans	12,000	12,000	15,000	15,000 [6]	15,000
Title III, Model Projects	16,000	16,000	8,000	5,000	None
Title IV, Training	8,000	9,500	8,000	None	None
Title IV, Research and Demonstrations	9,000	7,000	7,000	7,000 [6]	7,000
Title VII, Nutrition Program for the Elderly	100,000	99,600	125,000 [2]	125,000 [3]	88,000
Total, Administration on Aging	213,000	212,100	245,000	228,000	192,000
B. Rehabilitation Services Administration					
Basic State Grants	8,835	11,340 [4]	14,416 [4]	13,668	13,608
Facility Improvement	155	149 [4]	165 [4]	139	140
Total, Rehabilitation Services	8,990	11,489 [4]	14,581 [4]	13,807	13,748
Rehabilitation Training	42	28	12	12	12
Total, Rehabilitation Services Administration	9,032	11,517	14,593	13,819	13,760
C. Office of Native American Programs	---- [5]	188	188	150	150
D. Office of Rural Development	----	126	136	146	146

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1. Figures in the 1976 and 1977 columns are those in the President's 1976 and 1977 Budgets, respectively, except where noted to the contrary.

2. P.L. 93-554 (FY 1975 Supplemental Appropriations Act) appropriated $125 million for the Title VII Nutrition Program, but there was a direction in the conference report on the bill that carryover funds be used to build the program's operating level to at least $150 million for Fiscal Year 1975.

3. P.L. 94-206 (FY 1976 Appropriations Act for Departments of Labor and HEW and Related Agencies) appropriated $125 million of FY 1976 funds for the Title VII Nutrition Program, but directed that expenditures for the program be at the rate of $187.5 million per annum during 1976, using carry-over funds to reach that level.

4. Estimates

5. During 1973, ONAP was in the Office of Economic Opportunity.

6. Reprogramming request for $16,235,000 in State agency activities and $5,765,000 for research in both FY1976 and 1977.

Funds for Programs on Aging
(In thousands of dollars)

II. Social Security Administration	1973 Actual	1974 Actual	1975 Actual	1976 [1] Estimate	1977 [1] Estimate
Benefit payments to persons age 65 and over from social security trust funds:					
Disability insurance benefits (dependents).........	$21,000	$24,000	$25,000	$30,000	$34,000
Retirement and survivors' insurance benefits.............	33,247,000	37,898,000	43,066,000	48,973,000	56,098,000
Hospital insurance benefits.............	6,648,000	7,310,000	9,417,000	10,669,000	11,523,000
Supplementary medical insurance benefits...	2,391,000	2,587,000	3,335,000	4,034,000	4,861,000
Sub-total, benefit payments to persons age 65 and over from social security trust funds..............	42,307,000	47,819,000	55,843,000	63,706,000	72,516,000
Payments to persons age 65 and over from Federal funds:					
Supplemental Security Income payments......	---	850,000	1,817,000	1,838,200	1,950,000
Special benefits for disabled coal miners.	612,000	664,000	608,000	640,000	626,000
Sub-total, payments to persons age 65 and over from Federal funds......	612,000	1,514,000	2,425,000	2,478,200	2,576,000
Grand Total, Social Security Administration............	$42,919,000	$49,333,000	$58,268,000	$66,184,200	$75,092,000
III. Public Health Service					
A. Health Services Administration					
1. Bureau of Medical Services.......	5.977	6.471	15.424	14.152	18.105
2. Bureau of Quality Assurance					
Medical Care Standards.....	$4,719	$5,613	$6,255	$5,187	$4,187
Professional Standards Review Organization...........	4,475	12,805	18,745	26,175	34,100

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[1] Figures in the 1976 and 1977 columns are those in the President's 1976 and 1977 Budgets, respectively, except where noted to the contrary.

Funds for Programs on Aging
(In thousands of dollars)

III. Public Health Service (Continued)	1973 Actual	1974 Actual	1975 Actual	1976 Estimate 1/	1977 Estimate 1/
B. National Institutes of Health 2/	12,650 3/	16,544 3/ (17,989) 4/	15,989 3/	16,071 5/	26,220 6/
C. Alcohol, Drug Abuse, and Mental Health Administration					
(National Institute of Mental Health)	2,894	2,128 (2,487) 7/	4,163 (4,438) 7/	4,842	4,202
D. Health Resources Administration					
1. National Center for Health Statistics	900	872	1,841	1,870	2,756
2. National Center for Health Services Research	8/ 5,396	5,322	4,544	2,139	2,655
3. Bureau of Health Manpower	--	--	1,203	2,000	2,000
4. Facilities Development	41,762	38,953	50,986	61,306	43,761
IV. Social and Rehabilitation Service					
A. Assistance Payments Administration	1,287,752	$635,409 9/	3,762 10/	$3,939 10/	$4,000 10/
B. Public Services Administration	216,000	210,000	248,000 11/	299,000	318,000
C. Medical Services Administration	1,539,398	2,247,541	2,561,044	3,063,983	3,478,925
D. Office of Planning, Research and Evaluation	125	960	1,438	5,914	5,850
Total, Social and Rehabilitation Service	3,043,275	$3.093,510	$2,815,445	$3,372,836	$3,806,775

1/ Figures in the 1976 and 1977 columns are those in the President's 1976 and 1977 Budgets, respectively, except where noted to the contrary.

2/ Includes both intramural and extramural programs.

3/ Amounts for fiscal years 1973, 1974, and 1975 represented the aging programs of the National Institute of Child Health and Human Development.

4/ Figure in parentheses includes restored 1973 funds.

5/ Figure based on 1976 Revised President's Budget, including pay raise costs, for the National Institute on Aging.

6/ Budget estimate for the National Institute on Aging.

7/ Includes 1973 released funds.

8/ Includes Program Management costs associated with the Division of Long-Term Care ($639,000 per year).

9/ Includes one half-year payments and costs for program affected by P.L. 92-603.

10/ Adult programs in Guam, Puerto Rico, and Virgin Islands only.

11/ Estimate.

Funds For Programs on Aging
(In thousands of dollars)

V. Office of Education	1973	1974	1975	1976 Estimate	1977[1] Estimate
1. Library Resources	550	750	600	600	---
2. Adult Education	1,800	5,630	5,630	2,025[2]	2,145[2]
3. University Community Service and Continuing Education	130	130	1,326	---	---
TOTAL	2,480	6,510	6,230	2,625	2,145

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1. Figures in the 1977 column are those in the President's 1977 Budget.
2. Estimate--based upon the percentage of adults receiving services under this program who are aged 65 and over.

I. OFFICE OF HUMAN DEVELOPMENT

A. ADMINISTRATION ON AGING (AoA) - FISCAL YEAR 1975

1. INTRODUCTION

The fiscal year 1975 marked the second full operational year after enactment, on May 3, 1973, of the Older Americans Comprehensive Services Amendments of 1973 (P.L. 93-29). In fulfillment of this new mandate, the Administration on Aging (AoA) identified two major goals toward which its immediate and long-range efforts are being directed, and its work during the year emphasized these goals.

The first goal is to increase State and Area Agency on Aging capacity to:

- develop and implement annual operational plans to enable older persons to remain in their own homes or other places of residence;
- identify available resources;
- set priorities for action programs;
- coordinate existing services for older persons and pool available but untapped public and private resources for the support of services;
- promote the development of supporting services, such as information and referral and transportation; and
- promote the development of other social services for older persons as defined in the Older Americans Act.

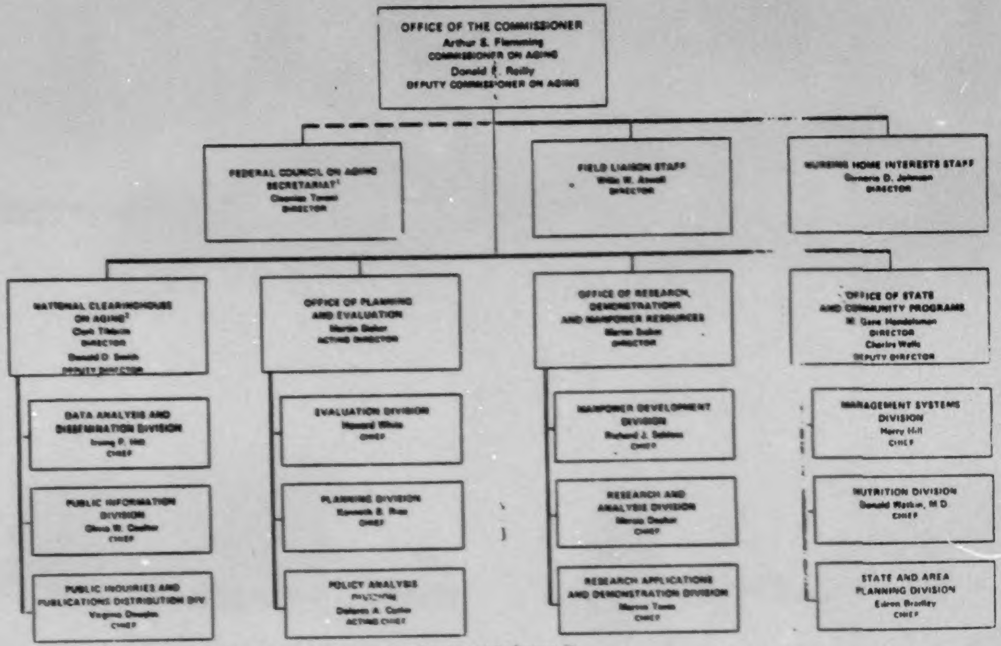
The second major goal is to increase the capacity of the Federal sector to promote comprehensive coordinated services for older persons through coordination of plans and programs which affect older persons. AoA's interagency efforts are being directed at influencing these Federal resources so that they can be brought to bear in developing and strengthening at the sub-State level a comprehensive system of coordinated services for older people.

Under its current organizational structure, which became effective in 1974, the Administration on Aging is composed of the following constituent units: (1) The Office of the Commissioner on Aging; (2) The Office of Planning and Evaluation; (3) The Office of State and Community Programs; (4) The Office of Research, Demonstrations and Manpower Resources; (5) The National Clearinghouse on Aging; (6) The Field Liaison Staff; and (7) The Nursing Home Interests Staff. On the next page, there is an organizational chart for the Administration on Aging.

The Office of Planning and Evaluation (OPE) carried out five-year forward planning activities, various evaluation activities, and legislative and policy analysis functions. OPE's legislative analyses make it possible for AoA to keep advised of bills, hearings, and other phases of the work of Congress, and their effect or potential effect on older persons. In this connection, AoA's legislative staff keeps an up-to-date compilation and analysis of all proposals pertinent to older persons which are introduced in the Congress.

Examples of OPE'S policy analysis activities in FY 1975 included an on-going, house analysis of major issues related to the conduct of programs under Titles II, III, IV, and VII of the Older Americans Act, as amended; an ongoing analysis of the effects of the energy shortage on older persons; an analysis of food stamp policies; continued attention to the transportation needs of older persons; continuing analysis of issues relative to the Supplemental Security Income Program (Title XVI of the Social Security Act); analysis of health care services provided under the Public Health Service and such services provided under Medicare and Medicaid; and

ADMINISTRATION ON AGING


OFFICE OF THE COMMISSIONER
Arthur S. Flemming
COMMISSIONER ON AGING
Donald F. Reilly
DEPUTY COMMISSIONER ON AGING
FEDERAL COUNCIL ON AGING SECRETARIAT[1]
[illegible]
DIRECTOR
FIELD LIAISON STAFF
[illegible]
DIRECTOR
NURSING HOME INTERESTS STAFF
[illegible] D. Johnson
DIRECTOR
NATIONAL CLEARINGHOUSE ON AGING[2]
Clark Tibbitts
DIRECTOR
Donald D. Smith
DEPUTY DIRECTOR
DATA ANALYSIS AND DISSEMINATION DIVISION
[illegible]
CHIEF
PUBLIC INFORMATION DIVISION
[illegible]
CHIEF
PUBLIC INQUIRIES AND PUBLICATIONS DISTRIBUTION DIV
Virginia Douglas
CHIEF
OFFICE OF PLANNING AND EVALUATION
[illegible]
ACTING DIRECTOR
EVALUATION DIVISION
Howard White
CHIEF
PLANNING DIVISION
Kenneth B. [illegible]
CHIEF
POLICY ANALYSIS DIVISION
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ACTING CHIEF
OFFICE OF RESEARCH, DEMONSTRATIONS AND MANPOWER RESOURCES
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DIRECTOR
MANPOWER DEVELOPMENT DIVISION
Richard J. [illegible]
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CHIEF
RESEARCH APPLICATIONS AND DEMONSTRATION DIVISION
Marvin Taves
CHIEF
OFFICE OF STATE AND COMMUNITY PROGRAMS
W. Gene Handelsman
DIRECTOR
Charles Wells
DEPUTY DIRECTOR
MANAGEMENT SYSTEMS DIVISION
Harry Hill
CHIEF
NUTRITION DIVISION
Donald Watkin, M.D.
CHIEF
STATE AND AREA PLANNING DIVISION
Edron Bradley
CHIEF

[1] The Federal Council on Aging is an independent unit which reports to the President and the Congress. The Federal Council on Aging Secretariat is housed in the Administration on Aging for administrative purposes only.

[2] Information and Referral Policy Staff are included in Office of Director.

thorough analysis and review of the recently-enacted Title XX social services program of the Social Security Act. Analyses in these and other areas have facilitated the development by AoA of formal working agreements with appropriate Federal agencies.

The Office of State and Community Programs (OSCP) serves as the focal point for development and assessment of the State and Community Programs on Aging (Title III) and the Nutrition Program for the Elderly (Title VII). It maintains information on programs of other Federal agencies and national voluntary agencies which have potential for relating to State and Area Agency on Aging planning and implementation of services for older people. In addition, OSCP develops regulations, policies, and guidelines for use by State and Area Agencies on Aging ; develops optional models and disseminates "best practice" suggestions for use by the Regional Offices, State Agencies on Aging and Area Agencies on Aging; develops and monitors, in cooperation with other AoA units, management information and reporting systems which provide updated information to facilitate planning and program adjustment for management efficiency at all organizational levels; and carries out other related functions.

AoA's Office of Research, Demonstrations and Manpower Resources serves as a focal point for coordination of research on aging by Federal agencies; provides the chairman and secretariat services to the Interagency Task Force on Aging Research, under the Interdepartmental Working Group of the Cabinet-level Domestic Council Committee on Aging; develops policy, supports projects and monitors progress related to research, demonstration, and manpower resources programs under Title IV of the Older Americans Act; and carries out other functions supportive to AoA's mandate to provide national leadership and expertise in encouraging new knowledge and upgrading competencies in the field of aging.

AoA's National Clearinghouse on Aging serves as the focal point within the Federal Government for the collection, analysis, and dissemination of information related to the needs and problems of older persons, and, wherever possible, develops and coordinates programs with other offices and agencies to fill gaps in information in the field of aging; develops policy for information and referral services; provides technical assistance to State Agencies on Aging in the development of information and referral services; provides the chairman and secretariat services to the Interagency Task Force on Information and Referral, and to the Federal Task Force on Statistics; produces a variety of professional and lay publications and audiovisual material on aging; publishes AGING magazine; develops special information campaigns; responds to numerous letters and telephone inquiries; and performs other related functions in the area of public information.

AoA's Field Liaison Staff assists Regional offices in keeping informed of continuing developments relative to the objectives and programs of the Administration on Aging; identifies difficulties being encountered by Regional offices in carrying out their duties and responsibilities; ascertains the degree of further assistance required from AoA Headquarters to ensure that Regional offices achieve national and operational planning objectives; and provides other related assistance to Regional office staff.

The Nursing Home Interests Staff provides technical assistance to community and advocacy groups which are working for the improvement of long-term care, assists in the development of alternatives to institutional care in collaboration with other agencies, serves as project manager for the Nursing Home Ombudsman Program, and provides technical assistance in the area of nursing home patient relocation.

In addition to completing its second operational year under new legislative initiatives and internal organizational arrangements, AoA also completed its second operational year as a component of the Office of Human Development (OHD) within the Office of the Secretary of Health, Education, and Welfare. As a part of this office, AoA has the advantage of working in close association with other OHD components which have responsibilities for the planning and delivery of services for special populations which overlap with AoA target groups, such as rural Americans, the handicapped, and Native Americans, including those of low income and racial minority status.

The remainder of this report provides detailed information relating to activities carried out during FY 1975 by the Administration on Aging under the Older Americans Act Amendments of 1973, including major program initiatives and grants and contracts awards.

2. STATE AND COMMUNITY PROGRAMS ON AGING

By the end of Fiscal Year 1975, the Administration on Aging had acquired two full years of management experience under the amendments of Title III and Title VII enacted by the Older Americans Comprehensive Services Amendments of 1973. The overall objective of the Title III program is to strengthen or to develop at the sub-State or area level a system of coordinated and comprehensive services which will enable older persons to live in their own homes or communities as long as possible. The purpose of the Title VII program is to secure for older persons who do not eat adequately the delivery of low-cost, nutritionally sound meals served in congregate settings where other services may also be provided.

Building upon the success of initial program implementation activities conducted during FY 1974, AoA's FY 1975 State and Community Program management activities were focused primarily toward providing develop mental assistance to State Agencies on Aging through a program of assessing and strengthening the management capabilities of the State Agencies on Aging and through them, those of the Area Agencies on Aging and Nutrition Projects. In addition, emphasis was directed toward establishing additional area agencies and toward achieving the goal of having an established Area Agency on Aging in every planning and service area in the nation, as well as expanding the quantity and quality of nutrition services to older persons.

A detailed discussion of State and Community Program activities and accomplishments is presented below.

a. State Planning, Coordination, Administration, and Evaluation

The Title III Program has as one purpose the strengthening of State Agencies on Aging to discharge, among others, the following responsibilities:

- to become a focal point in the State on behalf of older persons;
- to carry out those activities necessary for effective planning on behalf of older persons, including the establishment of measurable objectives for aging programs;
- to establish such procedures and mechanisms as are necessary to assure the effective coordination of all State planning and service activities related to the field of aging;
- to provide ongoing monitoring and assessment and to conduct periodic evaluations of activities and projects in the field of aging, with special emphasis on the work of Area Agencies on Aging; and
- to assure, in cooperation with Area Agencies on Aging, the availability of information and referral sources in sufficient numbers so that all older persons will have reasonably convenient access to such sources by the end of Fiscal Year 1975.

To be eligible for grants under Title III, States are required to submit annual State Plans on Aging to the Commissioner on Aging for approval. These plans are developed by the designated State Agency on Aging and submitted to the Commissioner by the Governor of each State. Each State Plan must identify the objectives which the State proposes to achieve during the year, and the plans of action which the State will implement for such activities as provision of technical assistance, monitoring of programs, conduct of coordination and pooling activities, provision of manpower development and training, and establishment of information and referral resources. The State Plan must also identify the manner in which the State has been divided into planning and service areas, the determination of which of these areas will have designated area agencies, and the manner in which resources will be allocated under the program.

In 1973 and 1974 State Agencies on Aging conducted Statewide surveys of their older population to determine the concentration of older persons with the greatest social and economic need and to assess the availability of resources to meet the identified needs. As a result of these surveys, State Agencies on Aging designated 621 Planning and Service Areas (PSA). By the end of FY 1975 462 Area Agencies on Aging, an increase of 50 from FY 1974,had been established within PSA's of highest priority to administer Area Plans for comprehensive and coordinated services for older persons.

During FY 1975, State Agencies' resources were directed toward the implementation of the approved State Plans on Aging for Fiscal Year 1974 and the development and implementation of State Plans for Fiscal Year 1975. The activities under the 1974 State Plans focused on establishing at the State level mechanisms for achieving coordination between Title III and other planning and services programs related to the purposes of the Older Americans Act; establishing State advisory committees on aging; establishing 412 Area Agencies on Aging, which covered seventy percent of the older population nationally, and approval of area plans on aging developed by these agencies; assisting in the development of agreements for coordinated activities between Area Agencies and the District Offices of the Social Security Administration; developing information and referral sources; and ensuring that at least one-half of the older persons who are recipients of services in areas where Area Agencies are located are those who come within the two primary target groups of this program - the low-income and minority elderly.

State Plans on Aging for Fiscal Year 1975 were approved in December 1974. FY 1975 State Plans include objectives related to the development of State level capabilities for technical assistance to Area Agencies on Aging and nutrition projects under Title VII, and for monitoring and assess ment of these programs; the negotiation of formal inter-agency agreements with the Social Services agency in each State; the development of other resources to increase the number of meals served in congregate settings; the establishment of additional Area Agencies on Aging; and the development of information and referral sources which meet standards established by the Administration on Aging. In addition to these efforts, State planning activities include action programs for the involvement of minority agencies and organizations in the delivery of services under Title III and Title VII; steps to assure equal employment opportunities for minorities, women and older people at the State and area levels; and actions designed to assist older persons who face problems associated with the energy crisis. FY 1975 State Plans also reflect a change from 621 to 591 in the number of planning and services areas (this number subsequently was adjusted by the States so that by the end of FY 1975 there were 585 planning and service areas).

In an effort to assist State Agencies on Aging in realizing their FY 1975 State Plan objectives, AoA has provided a wide range of technical assistance support to State Agencies and, through them, to Area Agencies on Aging and Nutrition Projects in such areas as indicated below.

(1) Inter- and intra-agency agreements with agencies whose programs affect older persons. In order to facilitate efforts of State and Area Agencies on Aging and nutrition projects in developing working agreements with social and rehabilitation agencies, AoA has concluded formal Federal level inter- and intra-agency agreements as follows:

- Information and Referral: a) with the Social Security Administration and the Social and Rehabilitation Service; and b) with fourteen other departments and agencies
- Medicaid: With the Medical Services Administration, Social and Rehabilitation Service
- Rehabilitation Services: With the Rehabilitation Service Administration, Office of Human Development
- Public Health Services: With the Public Health Service
- Social Services: With the Community Services Administration, Social and Rehabilitation Service, regarding the provisions of Title XX of the Social Security Act, to ensure that the needs of older persons are addressed.

In addition to these agreements, the Administration on Aging negotiated inter- and intra-departmental agreements in these areas:

- Urban Mass Transportation: With the Department of Transportation
- School Buses: With the Department of Transportation and the Office of Education
- School Lunch Program and Facilities: With the Office of Education
- Volunteer Programs: With ACTION
- Food Stamp Program: With the Department of Agriculture
- Community Development Program (Housing): With the Department of Housing and Urban Development
- Head Start Program: Joint collaboration between the Office of Human Development (Office of Child Development and Administration on Aging), and ACTION
- Nutrition Project Sites: With the Department of Housing and Urban Development
- Energy Crisis: With the Federal Energy Administration and other departments
- Affirmative Action: With the Civil Service Commission
- Research on Aging: Nine departments and agencies are involved in this effort
- Federal Executive Boards: With the Office of Management and Budget

The above agreements are discussed in detail in Section 3 of this report.

Pursuant to these Federal level agreements the States have reported that State Agencies on Aging and Area Agencies on Aging had concluded 498 inter-agency agreements by the end of FY 1975.

(2) Accessible Information and Referral Services. Toward the goal of assuring available and reasonably accessible information and referral services to older persons, AoA developed minimum requirements for such services and provided technical assistance and training to State Agencies on Aging, and through them, to Area Agencies on Aging in meeting these requirements. Information and referral activities are discussed in more detail in Section 7.

To further assist the States in reaching their information and referral goals, AoA has concluded a formal agreement with the Social Security Administration and the Social and Rehabilitation Service in the area of information and referral as indicated above. In addition to this intra-agency agreement, AoA has negotiated an inter-agency agreement on information and referral with fourteen other departments and agencies of the Interdepartmental Work Group on Aging. Sections 3 and 7 of this report contain more details on this agreement.

(3) State level capabilities for technical asistance to area agencies and Title VII nutrition projects.

During FY 1975 AoA provided policy guidance and technical assistance to State Agencies designed to assist them in increasing the capacities of area agencies on aging and nutrition projects in these areas: information and referral services development; data analysis; operational planning, information systems development; and grantee assessment and self-assessment.

(4) National Conference of State and Area Agency Executives on Aging.

In an effort to clarify the respective roles and functions of Regional Offices, State Agencies on Aging and Area Agencies on Aging with regard to the new Title III program as revised by the Older Americans Comprehensive Services Amendments of 1973, the Administration on Aging convened a three-day National Conference of State and Area Agency Executives on Aging in Washington, D.C. on December 9, 1974. Fifty-three State and Territorial Agencies were represented, 318 Area Agencies were represented, and 24 State Commissions on Aging.

The Conference, chaired by the Commissioner on Aging, was organized into plenary sessions and small working groups. Issues and problems that surfaced but were not resolved in the small working groups were addressed by the Commissioner in the plenary sessions. Those issues requiring further study were resolved by AoA after the Conference and the results subsequently communicated to the Conference participants as appropriate.

Of the $105 million FY 1975 funds allocated for the Title III Program, $15 million was alloted to the States to pay not more than 75 per cent of the cost of administration of the State Plans including planning, coordination, administration and evaluation at the State level. On the next page, there is a table showing how these funds are distributed by State.

b. Area Planning and Social Services

As previously stated, the overall objective of the Title III program is to strengthen or to develop at the sub-State or area level a system of coordinated and comprehensive services which will enable older persons to live in their own homes or communities as long as possible. A comprehensive and coordinated service delivery system, as defined in regulations, is one which provides necessary social services in a manner designed to:

Title III Funding Distributions to State and Area Agencies

		Col. 2 Planning & Service Areas	Col. 3 Area Agencies on Aging		Col. 4 Area Planning & Soc. Serv. Progs	Col. 5 State Planning Coordination Eval	& Admin.
	TOTALS	585	462		82,000,000	15,000,000	
1	Alabama	12	8		1,275,378	214,218	
2	Alaska	1	1		412,839	164,621	
3	Arizona	6	6		778,818	160,000	
4	Arkansas	8	8		917,313	160,000	
5	California	23	13		6,837,118	1,150,340	
6	Colorado	9	9		805,127	164,621	
7	Connecticut	5	5		1,095,877	180,304	
8	Delaware	1	1		453,319	164,621	
9	District of Columbia	1	1		512,800	160,000	
10	Florida	12	6		3,851,678	645,933	
11	Georgia	18	7		1,466,684	239,433	
12	Hawaii	4	4		465,093	164,621	
13	Idaho	6	6		512,747	164,621	
14	Illinois	13	13		4,056,725	667,499	
15	Indiana	16	12		1,823,907	299,812	
16	Iowa	8	9		1,228,604	201,957	
17	Kansas	11	10		958,018	160,000	
18	Kentucky	15	8		1,260,072	205,704	
19	Louisiana	8	4		1,190,605	195,711	
20	Maine	5	5		615,768	164,621	
21	Maryland	9	5		1,199,855	195,711	
22	Massachusetts	6	5		2,313,530	377,660	
23	Michigan	13	13		2,837,189	466,374	
24	Minnesota	13	6		1,464,192	240,682	
25	Mississippi	10	7		893,679	164,621	
26	Missouri	9	9		2,020,563	333,125	
27	Montana	7	7		507,783	164,621	
28	Nebraska	15	6		759,458	154,375	
29	Nevada	2	2		433,820	160,000	
30	New Hampshire	1	1		532,793	164,621	
31	New Jersey	21	20		2,672,531	439,308	
32	New Mexico	8	6		534,293	160,000	
33	New York	57	34		7,241,149	1,190,037	
34	North Carolina	17	12		1,670,745	272,746	
35	North Dakota	1	1		501,330	70,000	
36	Ohio	14	14		3,695,945	607,536	
37	Oklahoma	11	5		1,122,332	183,219	
38	Oregon	15	12		906,674	164,621	
39	Pennsylvania	41	41		4,772,557	784,508	
40	Rhode Island	1	1		593,774	164,621	
41	South Carolina	10	6		850,691	164,621	
42	South Dakota	1	1		527,639	164,621	
43	Tennessee	9	9		1,494,741	251,262	
44	Texas	26	16		3,877,150	632,937	
45	Utah	7	13		537,721	164,621	
46	Vermont	7	7		454,618	164,621	
47	Virginia	21	18		1,456,482	244,646	
48	Washington	15	7		1,219,259	204,790	
49	West Virginia	11	8		820,702	160,000	
50	Wisconsin	9	9		1,727,645	283,969	
51	Wyoming	2	2		413,964	160,000	
52	American Samoa	1	1		-0-	-0-	
53	Guam	1	1		205,000	50,000	
54	Puerto Rico	10	10		802,148	160,000	
55	Trust Territory	1	1		205,000	50,000	
56	Virgin Islands	1	1		205,000	50,000	

PHS-20-3 (Formerly HSM-785-3) STATISTICAL WORK SHEET
8/73

- facilitate accessibility to and utilization of all social services within the geographic area served by a public or private agency or organization,

- initiate, develop, and make the most effective use of social services in meeting the needs of older persons, and

- use available resources efficiently and with a minimum of unnecessary duplication.

The vehicle for realizing this objective is the establishment by State Agencies on Aging of a network of Area Agencies on Aging in State-defined planning and service areas. The designated Area Agencies on Aging are charged with the following major responsibilities:

- To become a focal point for leadership in the field of aging for its planning and service area;

- To engage in a continuous process of planning in order to define or redefine objectives and to establish priorities and to develop a system designed to improve the delivery of services;

- To make provision for an action program designed to coordinate the delivery of existing services for older persons;

- To make provision for an action program designed to pool available but untapped resources from both the public and private sectors in order to strengthen existing or to inaugurate new services;

- To take steps, in cooperation with State Agencies on Aging, designed to achieve the establishment or maintenance of information and referral sources in sufficient numbers to assure that all older persons within the area will have reasonably convenient access to such sources by the end of Fiscal Year 1975;

- To enter into contracts or to make grants for inaugurating or strengthening supporting and gap-filling services for older persons;

- To monitor and assess and conduct periodic evaluations of activities carried out under its auspices; and

- To develop comprehensive and coordinated programs for older persons throughout the planning and service area.

In order to qualify for Title III funds, the area agency must develop and submit to the State Agency for approval an area plan for activities on behalf of the older persons in the planning and service area encompassed by the area agency. After the State Agency approves an area plan, it awards funds to the area agency to support area agency activities and to enable the area agency to enter into grants with local service providers to carry out services programs set forth in the approved area plan.

Title III funds may be used by area agencies to support a broad range of social services. The types of services provided under area plans will be largely determined by the priorities established by the area agency based upon assessment of the status and needs of older persons within the planning and service area. Commonly supported services include transportation, outreach, escort, home-health and homemaker services and legal services.

Generally, an area agency is prohibited from providing social services directly. Exceptions occur in the case of information and referral service and coordination activities. Other social services may be provided directly only if specific

State Agency approval is granted. No such approval may be given unless it can be clearly shown in the area plan that the direct delivery of a service is necessary to assure an adequate supply of such service, and that no other agency in the planning and service area can and will effectively deliver such service.

During Fiscal Year 1975 area agencies on aging submitted to State Agencies for approval their required annual Area Plans on Aging, which included action programs for the following activities:

- coordinating the delivery of existing services for older persons and pooling untapped resources to strengthen existing services or inaugurate new services;
- giving priority to those services and activities to assist and benefit low income and minority older persons throughout the planning and service area;
- bringing about maximum possible coordination between the resources available under Title III and those available under the Adult Services and Medical Care Titles of the Social Security Act;
- establishing or maintaining information and referral sources so that all older persons in the planning and service area have reasonable access to these sources by June 30, 1975;
- demonstrating to local government how the priority established under General Revenue Sharing for social services for the poor or aged can be used in such a manner as to inaugurate new or strengthen existing services for older persons; and
- endeavoring to work out arrangements under which recipients of grants or contracts for nutrition projects under Title VII mutually agree with the area agency that such nutrition projects shall be made a part of the area's coordinated and comprehensive service system for older persons.

Toward the Administration on Aging goal of having an area agency on aging representing the concerns of older persons in every planning and service area of the country, there were 462 area agencies on aging established within 585 planning and service areas by the end of Fiscal Year 1975. This represents a national coverage of 80 percent of older persons.

Of the Fiscal Year 1975 funds allocated for the Title III program, $82,000,000 was alloted to State agencies for area planning and social services programs. Distribution of these resources is indicated in the table which appeared earlier in this report. Not more than 15 percent of these funds may be used for planning and administration at the area level. The balance of the allotment is available for social services, including the coordination of existing services and the pooling of untapped resources.

3. Nutrition Program for the Elderly (Title VII)

The Nutrition Program authorized by Title VII of the Older Americans Act, as amended, began operations early in fiscal year 1974. Under the provisions of Title VII, the Commissioner on Aging is authorized to make formula grants to States to establish and maintain community-based Nutrition Program project sites for the delivery of low-cost, nutritious meals, served primarily in congregate settings and with supportive services to persons 60 years of age and over and their spouses. Each Nutrition Program project must provide each participant at least one hot meal per day, five or more days a week, 52 weeks a year. The project must also provide to the extent that they are needed and not already readily available and accessible to participants those supportive services necessary to facilitate participation of eligible individuals in the meals program. Such services include outreach, transportation and escort services. In addition, projects are encouraged to assure as needed the provision of other supportive services including, education and counselling in health and welfare, information and referral services, shopping assistance and recreational services.

The program is designed to assist communities to meet the nutritional and social needs of older persons who do not eat adequately because: (1) they cannot afford to do so; (2) they lack the skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to to shop and cook for themselves; (4) they have feelings of rejection and loneliness which obliterate the incentive necessary to prepare and eat a meal alone.

The Nutrition Program operates within the same conceptual framework as Title III, since the delivery of low cost meals and related services is one component of a comprehensive coordinated services system. State and Area Agencies on Aging are urged to work out mutually satisfactory agreements with grantees under Title VII, designed to integrate the nutrition projects into area service systems, and to bring about meaningful coordination between them and the providers of services under Title III.

With funding authority for the Title VII Nutrition Program expiring in FY 1974, the Congress enacted extension legislation which the President signed into law (P.L. 93-351) on July 12, 1974, providing for a three-year extension of the program through fiscal year 1977. The authorization of appropriations are as follows: $150 million, FY 1975; $200 million, FY 1976; and $250 million; FY 1977. This legislation also required support for the Title VII program by the USDA donated food program. In the discussion of "Other interdepartmental Coordination," below, this is a description of how this was implemented during FY 1975.

On February 13, 1975, $98.6 million was alloted to the States for the Nutrition Program. A supplemental appropriation bill enacted by the Congress for fiscal year 1975 expanded appropriations for the Nutrition Program to $125 million. On March 17, 1975, an additional $25,400,000 was allotted to the States for the program. On the next page, there is a table showing how FY 1975 Title VII were distributed by States.

Consistent with the intent of Congress, the Secretary of Health, Education and Welfare on May 2, 1975 authorized the States to utilize the $25 million released on March 17 to build the operating level for the program to $150 million by the end of FY 1975.

During FY 1975, AoA concentrated on assisting State Agencies in their efforts to expand and strengthen the Nutrition Program.

In order to facilitate greater utilization of public resources other than Title VII by nutrition projects, AoA successfully negotiated interagency agreements at the Federal level as follows:

- Use of School Lunch Program and Facilities: With the Office of Education.
- Development of Nutrition Program project sites in Federally-sponsored or subsidized housing. With the Department of Housing and Urban Development.
- Use of school buses in transportation of participants to and from Nutrition Program project sites: With the Department of Transportation and the Office of Education.
- Development of transportation systems for carrying the elderly to and from Nutrition Program project sites: With the Department of Transportation.
- Federal subsidy for volunteers serving at Nutrition Program project sites: With ACTION.

Nutrition Projects Allotment FY 1975

		Number of Nutrition-Projects		Title VII Funds Allot-ed in FY'75			
	TOTALS	680		124,450,000			
1	Alabama	6		1,968,032			
2	Alaska	3		618,750			
3	Arizona	8		1,061,609			
4	Arkansas	9		1,383,697			
5	California	51		10,609,656			
6	Colorado	6		1,121,240			
7	Connecticut	11		1,702,105			
8	Delaware	4		618,750			
9	District of Columbia	5		625,865			
10	Florida	21		6,003,887			
11	Georgia	8		2,260,240			
12	Hawaii	4		625,865			
13	Idaho	7		625,865			
14	Illinois	30		6,373,657			
15	Indiana	14		2,862,774			
16	Iowa	12		1,906,515			
17	Kansas	6		1,474,110			
18	Kentucky	7		1,964,177			
19	Louisiana	12		1,868,757			
20	Maine	5		656,053			
21	Maryland	12		1,868,757			
22	Massachusetts	16		3,606,303			
23	Michigan	31		4,402,673			
24	Minnesota	17		2,272,093			
25	Mississippi	9		1,324,034			
26	Missouri	9		3,160,864			
27	Montana	5		625,865			
28	Nebraska	7		1,006,326			
29	Nevada	10		625,865			
30	New Hampshire	6		625,865			
31	New Jersey	23		4,194,764			
32	New Mexico	6		618,750			
33	New York	49		11,363,642			
34	North Carolina	24		2,604,331			
35	North Dakota	6		625,865			
36	Ohio	18		5,801,107			
37	Oklahoma	5		1,749,473			
38	Oregon	5		1,351,862			
39	Pennsylvania	45		7,490,941			
40	Rhode Island	7		625,865			
41	South Carolina	12		1,224,631			
42	South Dakota	8		625,865			
43	Tennessee	5		2,329,978			
44	Texas	16		6,043,649			
45	Utah	3		625,865			
46	Vermont	7		625,865			
47	Virginia	18		2,270,341			
48	Washington	15		1,892,998			
49	West Virginia	12		1,136,047			
50	Wisconsin	16		2,660,913			
51	Wyoming	3		625,865			
52	American Samoa	0		0			
53	Guam	1		329,375			
54	Puerto Rico	23		1,137,156			
55	Trust Territory	1		259,222			
56	Virgin Islands	1		309,375			

In addition, although no formal agreements have been signed, the Nutrition Program initiated during fiscal year 1975 the following actions with other departments and agencies:

- A joint program to evaluate the feasibility of veteran participation at Nutrition Program project sites as a means of reducing the rate of institutionalization and the duration of necessary institutionalization in Veterans Administration facilities: With the Veterans Administration.
- Authorization of Nutrition Program project sites to receive food stamps from eligible and certified elderly as their contribution toward meal costs: With the Department of Agriculture.
- Development of a system for utilization at Nutrition Program project sites of the high protein foods, meat and meat alternates provided by the Department of Agriculture's donated food program: With the Department of Agriculture at the Federal and Regional levels and the Distributing Agencies at the State level.

More details concerning the above agreements are provided later in this report.

In addition, AoA began planning for the development of technical assistance to nutrition projects, through the State Agencies, designed to assist them in progressing toward the following objectives:

- Introduction of the Nutrient Standard Method of Menu Planning and Monitoring;
- Use of the 1974 Recommended Dietary Allowances as standards in place of those promulgated in 1968;
- Use of greater quantities and varieties of UDSA-donated foods;
- Reduction in the salt content of USDA-procured meat products;
- Emphasis on more project-controlled meal service;
- More intensive education efforts in nutrition, health and aging with emphasis on educational spin-off effects to younger age cohorts;
- Greater numbers of effectively trained personnel to increase the outreach, escort, transportation and health services;
- Enhancement of mutual understanding between Area Agencies on Aging and Nutrition Program projects;
- Emphasis on giving top rank order priority to serving those in greatest need, particularly those elderly with low incomes and who belong to minority groups.

By the end of FY 1975 approximately 240,000 meals (an increase of 34,000 during fiscal year 1975) were being served daily at over 4,200 sites, (an increase of 100 sites during fiscal year 1975). According to periodic reports from the States, 64 percent of the meals were being served to older persons below the poverty threshold, and 25 percent were served to older persons in minority groups.

3. FEDERAL COORDINATION ACTIVITIES

The Older Americans Act, as amended, assigns responsibilities to the Administration on Aging to serve as a focal point within the Federal Government in matters pertaining to problems of the aged and aging. In pursuing its broad responsibilities as the Federal focal point for aging matters, AoA seeks:

(1) To improve interagency coordination of plans and programs which affect older persons.

(2) To serve as a clearinghouse for information pertinent to the problems of the aged and aging and to generate and analyze such information.

(3) To assess the progress and problems of programs which affect older persons with a view toward designing new strategies for improved program effect.

(4) To direct initiatives in aging programming and supporting research to meet demonstrated needs of the elderly.

The current long-range strategy of the Administration on Aging is to direct its limited resources primarily in support of its program management roles under Titles III and VII. Consequently, in regard to its research, information, evaluation, training and technical assistance functions, as well as in its implementation of the Title III and Title VII programs, AoA attaches high priority to identifying and pursuing those interagency activities which will contribute toward coordinating existing resources of other programs in order to develop and expand comprehensive services for older people at the local level.

Principal emphasis is being placed upon development of a national knowledge base on aging and coordination of those resources which currently or potentially impact on AoA target group populations. Priority attention has been directed at improving the delivery and utilization of specific services for the elderly, in particular, the low-income impaired and minority elderly, through joint agreements and programming with SRS, SSA, PHS, and DOT, in such areas as information and referral, adult social services (including transportation), Medicaid, rehabilitation services, community health and mental health services, and comprehensive health planning. With additonal program experience and continuing analysis, AoA will be in a position to identify other specific services needed by the elderly which cannot be developed through the State and Area Agency structure alone and which require new Federal initiatives. Barriers to increased cooperative programming will be identified, as well as infrastructural changes and interagency mechanisms and authorities which are necessary to facilitate AoA's full assumption of its broader Federal focal point role.

In carrying out its focal point activities during 1975, AoA has sought to utilize the potential for coordinated planning and programming inherent within the Committee on Aging [illegible] the Cabinet-level Domestic Council, the Federal Regional Councils, and the Federal Executive Boards. In addition, AoA has built upon previously existing interagency agreements and authorities, negotiated and developed new agreements, and has moved to implement its responsibility within the Department for improving Departmental coordination and effectiveness on behalf of the aged.

AoA believes that significant contributions toward ensuring appropriate attention to the interests of the aged have also been secured through review of major issues and proposed legislation and regulations related to Federal activities in such areas as the Supplemental Security Income program, Food Stamps, skilled nursing homes and intermediate care facilities, transportation, Federal energy policies, adult education, Medicare, Medicaid, adult social services, rehabilitation services, adult education, social security, retirement and employment policies for older workers, including the Older American Community Service Employment Program, authorized by Title IX of P.L. 93-29, and the Comprehensive Employment and Training Act programs, both of which are administered by the Department of Labor.

a. Interdepartmental Committees

(1) Domestic Council Committee on Aging - The Cabinet-level Domestic Council Committee on Aging, established in 1971, is chaired by the Secretary of Health, Education, and Welfare. The Committee is charged with, among other duties, the

responsibility for developing government-wide aging policy. An Interdepartmental Working Group, chaired by the Commissioner on Aging, has been established in order to assist the Cabinet Committee with its work.

During 1974 and 1975, the Working Group of the Domestic Council Committee established interdepartmental task forces to develop and implement plans for coordinated action programs in the four needs areas of nutrition, research, information and referral, and statistics. To develop and implement these plans, the task forces were convened with representatives from AoA, the Departments of Agriculture, Labor, Housing and Urban Development, Transportation, and Commerce, the Veterans Administration, and ACTION, as well as the Office of Education, Social and Rehabilitation Service, Social Security Administration, and the Public Health Service and the Office of Consumer Affairs within the Department of Health, Education, and Welfare. Other agencies which have been involved in coordination activities with AoA are the General Services Administration, the Community Services Administration (formerly the Office of Economic Opportunity) and the Federal Energy Administration.

It is expected that additional task forces will be convened in response to areas of need for interagency collaborative efforts as identified in on-going program analysis and State and Area Agency experiences.

Task Force on Nutrition - The Task Force on Nutrition during the first half of FY 1975 identifed and planned for ways in which existing Federal resources can be pooled to (1) increase the number of meals provided to older persons through Federal sources other than Title VII of the Older Americans Act, and (2) provide necessary supportive services to the older persons participating in nutrition programs.

Collaborative agreements in support of these objectives have been completed with HUD, DOT, OE, ACTION, the Department of Agriculture and the Veterans Administration.

Task Force on Research - The Task Force on Research in Aging has been engaged in a joint effort to develop ways of effectively coordinating Federal research and related activities which concern the older population. As a first step in that direction, member agencies of the Task Force were requested to consider a number of proposed research question areas in terms of their relevance to the research program, interests, and resources of the respective agencies. These research questions share a common focus in that they bear closely on the development of community service networks.

Once member agencies identified those questions which were consistent with their own research program directions, these interests were shared with the educational community and other interested groups and individuals and identified as an initial step in the development of a coordinated, Federal research program in aging.

In a concerted attempt to avoid duplication of research activities members of the Task Force have agreed to support a comprehensive inventory and analysis of past and current federally-supported research in the field of aging. A joint request for proposals was issued for a contractor to assume this task. Bilaterally, AoA has been working closely with the newly organized National Institute on Aging (NIA) to minimize problems of duplication and overlap in NIA and AoA aging research areas. These joint activities will be discussed further in this section under the sub-heading of Intradepartmental Coordination.

Task Force on Information and Referral - AoA has entered into an arrangement with fourteen Federal agencies to work in concert toward the objective of making I&R activities at the State and local levels more responsive to the needs of older persons. These Federal agencies have also agreed to monitor and evaluate their progress toward this objective.

As an outgrowth of Task Force activities, an Interdepartmental Working Group on Information and Referral was organized. In May 1975 this group effected an inter-agency working agreement among AoA, the Social

Security Administration and the Social and Rehabilitation Service for mutual support in the development of information and referral services for the elderly.

Other inter-agency activities in the area of I&R are included in the discussion of the work of the National Clearinghouse on Aging, later in this report.

Task Force on Statistics - Preparatory work to the establishment of a Federal Task Force on Statistics within the Interdepartmental Working Group on Aging has begun. An initial task force meeting is scheduled early in FY 1976 and is expected to consider plans for conducting an inventory of all Federal statistical data relating to the older population.

(2) Federal Regional Councils - Federal Regional Councils (FRC) have committees on aging in order to accelerate the development of coordinated programs for the delivery of services to older persons. The committees have sought to respond to State and local program development within each Region.

The committees on aging generally involve representatives of the various departments and agencies with programs serving older persons directly or indirectly. Some of the committees also include national voluntary agencies with Regional offices such as the American National Red Cross. One or two also include the directors of the State Agencies on Aging in either the full committee or in special subcommittees.

Examples of objectives which the Regions are focusing on include the following: (a) providing a retirement planning program for all Federal Employees; (b) reduction of the incidence of crime against the elderly with support from the Law Enforcement Assistance Administration, the Federal Bureau of Investigation and local police; (c) implementation of the CETA program; (d) printing resource directories of Federal resources available to older people; (e) concentration of Federal assistance in selected sites within the Region where services to the elderly are deficient; (f) developing with the States alternatives to institutional care; (g) assisting in the implementation of inter-agency asgreements; and (h) working with "natural communities" otherwise divided by political bounderies (like State and County lines) to plan more effectively and coordinate emergency efforts.

(3) Federal Executive Boards - In order to foster Federal-wide involvement in the development of information and referral services available to all older persons, the Federal Executive Boards (FEB) have identified the development and improvement of such sources as a priority assignment. Accordingly, in 25 of the the major metropolitan areas of the country, there is a Federal Executive Board, comprised of the highest ranking officials of each Federal agency in the area, assisting State and Area Agencies on Aging to carry out their I&R responsibilities. FEB involvement has grown out of earlier cooperative activities undertaken among AoA, the Office of Consumer Affairs, and the Office of Management and Budget.

Most FEB task forces during 1975 produced or updated community directories of services to older persons. Others began an effort to coordinate information and referral services. Several are instituted training programs for employees in the FEB member agencies to improve the handling of problems of older persons who asked the agencies for assistance. Some FEB task forces also instituted community-wide publicity campaigns to inform older persons about the information and referral services.

The Federal Executive Boards have developed workplans for FY'76. These plans include efforts to assess the programs developed in FY'75. In addition they include programs of training telephone receptionists to improve the responsiveness of Federal offices to older persons as well as utilizing the technical assistance of the Federal Energy Administration in addressing the problems created by the energy crises.

b. Other Interdepartmental Coordination

In addition to the multilateral cooperative activities pursued through the Interdepartmental Working Group, AoA during 1975 built upon existing bilateral agreements and cooperative arrangements with other Departments and agencies.

Department of Transportation - DOT and AoA effected a joint working agreement in June 1974 which pledged mutual cooperation and coordination in actions designed to achieve increased mobility of older persons by improving their access to public and specialized transportation systems in urban areas. The agreement took note of the fact that DOT set aside $20 million in fiscal year 1975 funds from the Capital Assistance Program to implement Section 16(b)(2) of the Urban Mass Transportation Act of 1964, which provided for capital grants and loans to private, nonprofit corporations and associations for transportation of the elderly and handicapped. The $20 million level for such grants and loans has been maintained for FY 1976. Title III, Title VII and other sources, including general revenue sharing funds, are available for support of operating costs for aging transportation projects.

A revised working agreement with DOT has been developed which includes not only UMTA's programs but the rural highway transportation demonstration program administered by the Federal Highway Administration, as well as shared or cooperative research and demonstration activities.

On January 1, 1975, the Administration on Aging transmitted to the Secretary, to the President and to the Congress, a report on "Transportation for the Elderly: The State of the Art." The report is required under Section 412 of the Older Americans Act, as amended in 1973. Subsequent to the submittal of the report to Congress, the Commissioner on Aging conducted public hearings on major issues raised in the report in the following four cities: Philadelphia, Pennsylvania; Kansas City, Missouri; Sanford, North Carolina; and San Francisco, California.

Findings from the report and the subsequent field hearings indicated a crucial need for greater coordination of program resources for transportation purposes in order to make more efficient use of available funds. The revised 1975 AoA/DOT joint agreement can be a major step in that direction.

Department of Transporation/Office of Education - In May of 1975, the Administration on Aging, the Department of Transportation and the Office of Education, DHEW, signed a statement of understanding related to the use of school buses for older persons. The three agencies pledged to explore methods for increasing the mobility of older persons through the use of school buses, with special attention devoted to those older persons residing in rural areas.

Department of Housing and Urban Development - HUD and AoA have jointly supported a program within the National Center for Housing Management to develop a short-term training program and appropriate materials for managers of housing for the elderly. Also involved in this program are trainers from a variety of organizations specializing in housing management. These individuals will then be expected to develop additional training under the sponsorship of their respective organizations and thereby establish a national delivery capability for the program.

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Efforts were also continued by AoA, HUD, and the Law Enforcement Assistance Administration, in regard to security for the elderly in housing projects. This topic was also chosen as one of the priorities of the Region III, Mid-Atlantic Federal Regional Council Human Resources Committee's Task Force on Problems of the Elderly.

In June 1975, AoA and HUD transmitted a joint issuance to their respective counterparts at the State and local levels, on the Community Development Program, under Title I of the Housing and Community Development Act of 1974. The joint issuance includes a description of the Community Development Program and accompanying guidance to State and Area Agencies on Aging on ways in which Community Development can be most effective for older persons, with special emphasis on how these funds can be used for the development of senior centers.

Additionally, in early 1975 a statement of understanding was signed by the Commissioner of AoA and the Assistant Secretary for Housing Management, HUD, for the purpose of encouraging States and communities to explore the possibilities of locating new nutrition sites in public housing facilities thereby enabling these projects to make maximum use of resources available through HUD local housing authorities.

Department of Commerce - An interagency agreement was made with the Bureau of the Census for their Census Use Study group to develop a social statistics system for use by State and Area Agencies on Aging.

Current plans call for the completion of a prototype State system in 1975. A manual and instructions for duplication in other States will be completed some time in 1976.

ACTION - AoA and ACTION developed joint program objectives during Fiscal Year 1974, under which maximum coordination and mutual support between the two programs was pledged. The ACTION objective included the designation of at least one ACTION program to be designed to provide volunteer opportunities for older persons in each planning and service area in which an area agency is designated and an area plan is approved. In addition, AoA and ACTION agreed to cooperate in the placement of volunteers in nutrition projects supported under Title VII. Under the terms of the joint objective, State Agencies on Aging were also to provide for maximum utilization of senior volunteers and to support and enhance the objectives of the senior volunteer programs.

The AoA/ACTION joint agreements have resulted in some 186 area agencies utilizing ACTION's Older American Volunteers during FY 1974 in a variety of activities, including assisting staff of area agencies in information and referral and in social services activities under approved area plans. In addition, 129 Title III projects in planning and service areas without designated area agencies on aging and 279 nutrition projects were utilizing ACTION's older volunteers in FY 1974. States reported a total of 27,596 of ACTION's older volunteers participating in Title III and Title VII programs throughout the country.

Based upon findings of an assessment of activities conducted under the fiscal year 1974 joint program collaboration, new fiscal year 1975 joint objectives have been developed and an agreement signed. The agreement expands the scope of the fiscal year 1974 joint objectives, with greater emphasis placed on joint activities at the State and local levels.

A Joint Announcement of Collaboration between the Office of Human Development (Office of Child Development and the Administration on Aging) and ACTION/National Older Americans Volunteer Programs was signed in August 1974. The Joint Announcement was distributed to OCD Head Start grantees and delegate agencies, State Agencies on Aging, and Foster Grandparent Program Sponsors and/or Retired Senior Volunteer Progam Sponsors. The agreement is designed to promote expanded involvement of older volunteers in the Head Start program. Site visits were made to five exemplary Head Start/RSVP programs, after which work began on the preparation of policy and guidance materials for use in developing programs so that additional older volunteers will have opportunities to serve in Head Start programs. These policy-guidance materials will be distributed to local programs for their use in working out collaborative efforts at the local level.

Federal Energy Administration - AoA has attempted to ensure that the special problems of older people are granted appropriate attention in all activities of the Federal Energy Administration (FEA) and its predecessor agency, the Federal Energy Office. In addition to reviewing and commenting upon virtually all energy and fuel allocation regulations and plans, AoA, with FEA, and ACTION, initiated a study of aging programs to determine and plan for ameliorating the effects of gasoline shortages on volunteer participation.

The Federal Energy Administration is participating in the Domestic Council Committee on Aging Task Force on Transportation and Energy. Along with other members of the Task Force, the FEA signed an agreement on energy conservation which in part was designed to identify resources that are available for the winterization of older persons' homes. The Administration on Aging also participates in the Federal Energy Administration Consumer Affairs Office's Task Force on Energy and Low Income Persons. Two FEA reports on the impact of the Energy Crisis were also reviewed and commented on by the Administration on Aging.

Department of Agriculture - AoA and the Department of Agriculture developed an agreement whereby the Department of Agriculture will promptly certify nutrition projects as eligible to accept food stamps toward the purchase of congregate meals in Title VII Nutrition for the Elderly meal sites.

In addition, AoA worked with USDA Federal and Regional staff and State Distributing Agencies in the development of a system for utilization at Nutrition Program project sites of the high protein foods, meat and meat alternates provided by the U.S. Department of Agriculture's donated food program. (With the U.S. Department of Agriculture at the Federal and Regional levels and the Distributing Agencies at the State level.)

P.L. 93-351, the 1974 Amendments to the Older Americans Act of 1965, amended Section 707 of the Act to require the Secretary of Agriculture to maintain an annually programmed level of assistance for the Title VII Nutrition Program of not less than 10 cents per meal adjusted on an annual basis each fiscal year after June 30, 1975, to reflect changes in the series for food away from home of the Consumer Price Index published by the Bureau of Labor Statistics of the Department of Labor.

The Department of Agriculture, working closely with the Administration on Aging, issued regulations implementing this amendment. Subsequently, both the Department of Agriculture and the Administration on Aging issued Instructions and Technical Assistance Memoranda advising the Regional Offices, State Distributing Agencies and State Aging Agencies on the details of the donated food program. In addition, Regional meetings were held at which representatives of State Distributing Agencies and State Agencies on Aging were briefed by Washington-based Department of Agriculture and Administration on Aging staff in regard to the management of the program.

In FY 1975, because the program started late in the year, the donated food distributed consisted only of processed cheese and beef packed in its own juice. The actual value of these two foods distributed during FY 1975 (based on $0.10 per meal served from Mid-October to the end of the Fiscal Year) approximated $3,263,000.

Together, the U.S. Department of Agriculture and the Administration on Aging have planned to expand the variety of foods available to Nutrition Program projects. Details of this expansion and the management changes it entails were topics of Instructions and Technical Assistance Memoranda transmitted to State Agencies on Aging.

Department of Labor - The Administration on Aging has worked closely with the Department of Labor in its development of regulations for implementation and operation of the Comprehensive Employment and Training Act of 1973 (CETA) and for the Older American Community Service Employment Program authorized by Title IX of the Older Americans Comprehensive Services Amendments of 1973. The State and Area Agencies on Aging have also been encouraged to take an active role in the implementation of these programs. Technical assistance material has been developed and transmitted to the State and Area Agencies on Aging on the possible actions that can be taken to ensure that the employment-related activities of the Department of Labor and the State and Area Agencies on Aging are coordinated, and that the needs of older persons are considered in the development by manpower prime sponsors of comprehensive manpower plans.

Also, information has been provided on the availability of funds under the Emergency Job Programs under the Comprehensive Employment and Training Act, and State and Area Agencies on Aging have been urged to work with manpower prime sponsors to ensure that older persons are included among the persons hired under the program.

In addition, the Department of Labor, under an agreement with AoA, is currently working on a study to enable the Administration on Aging to carry out its responsibility for appraising existing and future personnel needs in the field of aging. Details of this study are presented in discussion of training in Section 4, below.

Civil Service Commission - In order to help insure that State Agencies are engaged in meaningful affirmative action activities, AoA and CSC agreed to make joint visits to State Agencies on Aging for the purpose of assessing State Agency progress. A written agreement to this effect for fiscal years 1975-1976 was finalized and transmitted to the field in November, 1974.

c. Intradepartmental Coordination

The Administration on Aging has been intensively involved in the development of a series of formal agreements with various agencies within the Department of Health, Education, and Welfare, especially SRS, PHS, and SSA. These efforts are designed to improve coordination of State and community activities in the areas of information and referral adult social services, rehabilitation services, community health and mental health services, and comprehensive health planning. Building upon cooperative arrangements pursued during 1974 these formal agreements reflect AoA's commitment to identify and plan for ways in which Departmental resources can be brought to focus effectively upon the needs and interests of older persons. In addition, AoA has been engaged in collaborative activities with the National Institute on Aging (NIA), to ensure coordination of NIA's research objectives with those of AoA.

Social Security Administration - AoA has continued to work with SSA on the establishment of information and referral services for older people and on the dissemination of information concerning the Supplemental Security Income Program. A comprehensive discussion of I&R activities is presented in the discussion of the National Clearinghouse on Aging in Section 7 below. AoA has reviewed and commented on virtually all regulations pertaining to the SSI program, and in collaboration with SSA has developed and implemented a special project called "SSI-Alert" to inform potentially eligible older people about SSI benefits and options. "SSI-Alert" is discussed in Section 8 of this report.

Public Health Service - AoA has been working to update a joint agreement with the PHS under which joint efforts have been focused on cooperative funding of research and demonstration grants, health technical assistance to areawide model projects formerly funded by AoA, planning for long-term care and alternatives to institutionalization, and development of objectives for joint action in health planning. AoA has also consulted with PHS components, namely the Health Services Administration, Health Resources Administration, and the Alcoholism, Drug Abuse, and Mental Health Administration, relative to the cosponsorship of selected evaluation projects.

A second joint working agreement has been signed and distributed by the Administration on Aging and the Public Health Service through the Office of Nursing Home Affairs which has as its objective the improved delivery of coordinated health and social services to older persons.

Programs related to the elderly are administered by all PHS agencies, including the National Institute on Aging, NIH, serving important Department-wide roles in the areas of research, planning and impact studies.

The agreement is designed to bring about greater coordination between the resources available under the Public Health Service Act and the resources available under Titles III and VII of the Older Americans Act, through joint planning, programming and implementation at the Federal, State and local levels. Specific appropriate activities for coordinated action are noted in the agreement.

AoA has also worked with PHS components and the HEW Office for the Handicapped, formerly the Office of Mental Retardation Coordination, to identify problems of mentally retarded patients in nursing homes. AoA and PHS staff also worked with the Division on Aging of the National Associtio of State Mental Health Directors to try to effect cooperation with State Agencies on Aging.

Office of Nursing Home Affairs, PHS - During 1974 AoA was assigned additional responsiblities in the area of long-term care, and met regularly with staff of the Office of Nursing Home Affairs to coordinate long-term care-related activities, especially in the matter of improving the quality of institutional care. In these activities, AoA has served as a member of an Interagency Advisory Group, whose other members include representatives from the Office of the Assistant Secretary for Health, the Office of Nursing Home Affairs, the Social Security Administration, the Social and Rehabilitation Service, the Public Health Service, and the Office of Fire Safety Engineers.

In July of 1974 seven Nursing Home Ombudsman Demonstration Projects were formally transferred from PHS to AoA. Accordingly, to meet this and other new responsibilities related to nursing home concerns, AoA has added a Nursing Home Interests unit to its staff. The functions of the Nursing Home Interests Staff are discussed in Section 1 of this report.

Office of Education - AoA has cooperated with the OE Bureau of Libraries and Learning Resources on a demonstration project utilizing libraries as information and referral centers. In cooperation with the Bureau of Adult, Vocational and Technical Education, AoA has also fostered the cooperation of State Supervisors of Home Economics Education as a resource in the nutrition education program mandated under Title VII of the Older Americans Act.

An agreement signed in January 1975 between the Commissioner on Aging and the Commissioner of Education encourages the expanded use of public school facilities for serving meals to older people. Included in this agreement is provision for a variety of educational, recreational, cultural and other community services and volunteer opportunities for older people.

AoA has also worked with the Bureau of Adult Education to ensure that the educational needs of older adults are more adequately considered in special projects funded under the Adult Education Act.

Social and Rehabilitation Service - AoA and SRS have agreed to co-sponsor selected program evaluation studies directed at assessing long-term care alternatives and the development of non-vocational rehabilitation goals for older people.

Agreements have been developed with the Community Services Administration (CSA), Medical Services Administration (MSA) and the Rehabilitation Services Administration (RSA).

The agreement with CSA signed in July 1975 is designed to promote efforts at the Federal, State, and local levels to coordinate planning, service development and delivery, and manpower development activities of the aging and nutrition programs under Title III and Title VII of the Older Americans Act and the social service program under Title XX of the Social Security Act.

The agreement delineates the steps that will be taken at the Federal level to achieve coordination, including:

- establishment at the Central Office and Regional Office levels of mechanisms for joint identification and resolution of policy and administrative barriers to coordinated planning and integrated provision of services to older persons;
- preparation of joint policy issuances and technical assistance material, and joint provision of technical assistance and consultation to the State staff of the Title III and Title VII and Title XX programs;
- sharing, and coordinating where feasible, annual forward plans and operational plans;
- sharing the findings of research and demonstration projects on planning and services delivery;
- sharing materials that have been developed for the States on planning and needs assessment activities;
- joint funding of an evaluation of the Title XX program, a portion of which will address how effectively Title XX serves older persons; and

- encouraging the respective State Aging and Social Services Agencies to take steps to maximize coordination between the two programs at that level, including the development of written joint agreements.

There has been signed and transmitted to the field an agreement with MSA which has as its objective the improved delivery of coordinated health and social services for older persons. The agreement is designed to bring about greater coordination of resources available under the Medical Assistance Program and Title III and Title VII of the Older Americans Act.

In May 1975 RSA and AoA signed a joint working agreement to improve delivery of of coordinated health and social services for impaired older persons. The agreement is intended to provide a framework within which to structure joint efforts on consultation and sharing of expertise, planning and implementation of coordinated service delivery programs and recommendations for future program directions.

National Institute on Aging - The National Institute on Aging (NIA) was established by the Research on Aging Act of 1974 to carry out research on various aspects of aging, including biological, medical, and behavioral fields of study. The 1974 legislation also created a National Advisory Council on Aging to offer guidance and counsel in developing the Institute's program mission and research priorities.

To ensure coordination of NIA's research objectives and emphases with that of other Federal Departments and agencies - particularly the Administration on Aging - there have been from the outset close working relationships between NIA and AoA in the fields of research and evaluation.

- Joint AoA-NIA Research Activities

  AoA is represented on the National Advisory Council on Aging of NIA by the Director of the Office of Research, Demonstrations and Manpower Resources (ORDMR). In that capacity, AoA has been directly involved over the past year in the formative stages of NIA's program decisions. This has helped to minimize problems of duplication and overlap in NIA and AoA aging research areas, with NIA emphasizing support of biomedical and behavioral research and AoA focusing on the social aspects of aging. Other cooperative arrangements between NIA and AoA in the field of research include:

  . Joint membership on the Interdepartmental Task Force on Research in Aging. Under the direction of the Task Force , chaired by AoA, a contract has been awarded to conduct a comprehensive inventory and analysis of past and current Federally-supported research in aging. AoA and NIA are among the four agencies participating in the joint funding of this project.

  . AoA representation on the Interagency Advisory Committee for Research on Aging of NIA. The Interagency Committee is engaged in important staff work for NIA pointing toward the drafting of an HEW plan for research on aging. The Research on Aging Act of 1974 directs the Secretary, Department of Health, Education, and Welfare to develop such a plan for submission to the Congress and the President by May 1976. NIA is the lead agency for organizing this effort. ORDMR represents AoA on the Interagency Advisory Committee. ORDMR staff members have participated on an ongoing basis in the Committee's activities. Moreover, ORDMR has detailed a senior staff member to NIA for four (4) months to assist in the development of the Departmental plan for research on aging.

- Joint AoA - NIA Evaluation Activities

AoA provided the chairmanship for the sub-committee on evaluation of the Task Force to establish NIA. Through its membership with NIA on the ad hoc Intra-HEW Committee on Evaluation in Aging, which evolved from this sub-committee, AoA continues its participation in the development and coordination of evaluation in aging activities within HEW.

4. RESEARCH AND DEMONSTRATIONS

a. Research and Demonstration

The Administration on Aging's research and demonstration program supports projects which add to existing knowledge in a variety of areas which may be useful in the development and improvement of aging programs. The primary source of funding for R&D projects in aging is Title IV,Part B of the Older Americans Act of 1965 as amended. During FY 1975, 113 new and continuing projects received financial assistance.

The new projects (a total of 72) continued to be developed in response to a research and development strategy which focuses on directing research toward knowledge useful to effective conduct of new programs authorized by the Older Americans Comprehensive Services Amendments of 1973, and to progress toward fulfilling the national objectives for older persons outlined in Title I of the Older Americans Act of 1965, as amended.

A Dissertation Research Program was initiated by the Administration on Aging in fiscal year 1975 to provide support for doctoral research in the several research areas addressed by the new projects. Of the 72 new project awards made in FY 1975, 45 were dissertation research grants.

Continuation projects (41) are those which were initiated prior to July 1974 and received additional support in FY 1975 from funds authorized by Title IV, Part B. These complement the new emphasis on planning and coordination by continuing the search for new knowledge on approaches to developing and organizing services designed to enhance potential for independent living and reduce the need for institutionalization among the elderly.

(1) New Awards

The following summary of the new start research projects is organized under the four research issues of the 1975 Research and Development document:

(a) Aging Processes (exclusive of Biological Processes).

Research funded under this area is expected to permit identification and understanding of variables and processes that contribute to the aging phenomenon. Such knowledge will assist in the development and implementation of programs responsive to the capabilities and functionings of the elderly. More specifically the following will be investigated:

- information and knowledge about the strengths and weaknesses of the elderly to compete for a fair share of goods and services;
- knowledge to develop responsive service systems directed toward the problems of old age;
- basis for assisting service providers to understand the special problems of the elderly.

Ten new grants bear directly on research in this area:

- Grants to study the changes of and problems associated with coping ability among older persons were awarded to:
  - Community Research Application ($50,769)
    New York, New York
  - University of Maryland ($66,899)
    College Park, Maryland
- Grants to conduct research on the problems of decision-making of older persons and its associated processes were made to:
  - University of Chicago ($76,144)
  - University of Missouri-Columbia ($115,934)
  - Catholic University ($118,013)
- The University of Southern California will examine the policy and program implications of investigating different non-chronological approaches to defining the aging process. ($45,565)
- The American Institute for Research will be investigating the identification of opportunities for improving the quality of life of older age groups. ($85,967)
- Bowling Green State University will conduct research to assess the differential levels of communication competence in older people. ($16,769)
- The University of Florida will investigate the nature of changes in cognitive factor structure concomitant with age in order to gain a clearer theoretical understanding of the kind of qualitative differences which may be occurring. ($23,790)
- The University of Chicago will analyze the relevant informal and formal institutions that provide resources for coping, and will study the relationship between a person and such resources that lead to effective coping behavior. ($131,211)

In addition, 17 dissertation research grants pertinent to this subject area were awarded. ($5,000 per grant)

(b) Descriptions of the Older American Population

Research funded under this area is expected to provide knowledge about the characteristics, attitudes, behaviors and distributions of older persons. Such knowledge will permit formulation of policies and programs which will facilitate the achievement of equal opportunity and access to the objectives specified in Title I of the Older Americans Act of 1965, as amended.

More specifically, the following will be investigated:

- the characteristics, attitudes, behaviors, or distributions of older persons (either current or future) which require consideration relative to existing and future policies and program designs;
- unanticipated or undesired changes or trends which have been fostered by policies or programs affecting the elderly;
- changes or trends which affect the application of intervention mechanisms;

- sub-populations of elderly, how they differ, and the implications of these differences for policy, planning, and the application of intervention mechanisms.

Two grants bear directly on research in this area:

- The Research Foundation of the State University of New York will investigate distinctive patterns of influencing variables on the differential perception and objective definition of elderly sub-population. ($27,463)

- The University of Georgia received a grant to identify and analyze the characteristics of rural elderly populations and their differential life styles. ($49,750)

In addition, 14 dissertation research grants pertinent to this area were awarded. ($5,000 per grant)

(c) Social and Environmental Conditions Affecting the Elderly

Research funded under this area is expected to provide knowledge of social, economic, and environmental forces which impinge on the ability of the elderly to secure and maintain "freedom, independence and free exercise of individual initiative in planning and managing their own lives" (Objective specified in Section 101 (10) of the Older Americans Act).

Specific research issues to be investigated include:

- national policies which create unique crisis situations for the elderly;

- economic and social forces which enhance or diminish the social or economic capital of the elderly;

- values, mores, stereotypes, and social conditions in the population at large which inhibit or facilitate the achievement of freedom and independence of the elderly;

- responses of the elderly to social and environmental conditions which impact negatively on their freedom and independence;

- types of intervention at the national, State and local level which can reduce negative impact of undesirable conditions which affect the elderly.

Six grants were awarded which bear directly on research in this area:

- The University of Missouri will analyze the factors related to residential segregation of the aged in American cities. ($28,597)

- The National Opinion Research Center of Chicago will study the psychological determinants of public support for five social welfare groups. ($49,799)

- The University of Florida will investigate ways of improving the older person's purchase decisions. ($39,784)

- The University of Michigan will conduct research on the factors influencing the abandonment of private homes by the elderly. ($137,473)

- The Philadelphia Geriatric Center will study the factors related to the changing housing needs of urban and rural elderly. ($55,706)

- The University of California at Davis will analyze life styles of the elderly as they relate to consumer behavior. ($20,955)

In addition, four dissertation research grants pertinent to this subject area were awarded. ($5,000 per grant)

(d) Intervention Mechanisms

Research funded under this area is expected to provide knowledge descriptive of intervention mechanisms and the responses of the elderly to those interventions. Such knowledge will provide the understandings necessary for the development, organization and delivery of service, as well as the coordination of delivery systems as supported under Titles I, III, and VII of the Older Americans Act of 1965 as amended.

More specifically, the following will be investigated:

- what intervention mechanisms exist or are possible and how they differentially affect the well being of Older Americans;
- what tools and techniques are required for different intervention mechanisms; how these may differ by application to sub-population groups of elderly;
- what resources are required for different intervention mechanisms; how can resources be uniquely identified as critical to certain sub-populations of the elderly?

Eight grants bear directly on research in this area:

- The Institute for Economics and Social Measurements received a grant to develop and analyze techniques for translating units of need into units of service. ($91,642)
- The Urban Institute received a grant to increase the information about factors on which institutional placements are based, and to improve the quality of care which is provided. ($161,760)
- The State Communities Aid Association of New York will study the first year's operation of Title XX of the Social Security Act. ($154,218)
- Columbia University received a grant to develop information on the uses and gratifications of the mass media for aged persons, and to determine whether a weekly newspaper produced by aged persons can help satisfy individual needs and raise morale. ($67,063)
- A grant was awarded to the University of Massachusetts to examine the methodological problems of accurately measuring and forecasting the need for long-term health care services for the elderly. ($168,566)

- The School of Medicine of the University of Pennsylvania received a grant to develop models for analysis depicting strategies of decision-making within the context of nursing home closings, focusing on inter-organizational relationships within long term care/nursing home facilities. ($80,786)

- The Governor's Citizens Council on Aging of Minnesota will conduct research on a comparison of in-home and nursing home care for older persons. ($183,154)

- The Curative Workshop of Milwaukee received a grant to demonstrate the effectiveness of an avocational counselling program for older persons. ($74,201)

In addition, ten (10) dissertation research grants pertinent to this subject area were awarded. ($5,000 per grant)

(2) Continuation Projects

The continuation projects largely focus on better ways to develop and organize services to help the vulnerable elderly return to or remain in their own homes or other appropriate settings. A number of these projects are described below in order to illustrate the wide variety of areas within which investigations and new knowledge on behalf of older persons are being undertaken. A number of these projects receive support from other Federal agencies, in addition to the Title IV funds provided by AoA.

- The University of Southern California Gerontology Center has organized, evaluated, and analyzed research data, concepts, theories and issues on the biological, psychological and social aspects of aging for publication in three *Handbooks in Gerontology*.

- The School of Social Service Administration, University of Chicago, has initiated research on a series of models that show the effects on older persons of a wide range of service delivery methods. ($42,214)

- The Colorado Department of Institutions, Denver, is testing the feasibility of specialized boarding homes for elderly persons who have had or continue to have mental problems. ($75,347)

- A grant to the International Center for Social Gerontology, Washington, D.C., will provide a comprehensive literature review on congregate housing for the elderly, placing special emphasis on European experience in this field. The grant also aims at a systematic analysis of the environmental, economic, cultural and other factors that favor success of such programs, with implications for legislative and administrative action concerning congregate housing programs in the United States. ($87,990)

- Grant research by the Center of Demographic Studies, Duke University, Durham, North Carolina, will indicate what combinations of factors cause older persons to adopt independent, congregate, or institutional patterns of living arrangement. ($94,391)

- A grant to the Wilmington Housing Authority, Delaware will support a literature search of current knowledge about the causes and effects of social isolation among the elderly. An analysis of community programs focused on combating social isolation will also be undertaken. ($92,427)

- Catholic University of America, Washington, D.C., has been awarded a grant to develop models depicting decision-making patterns of older persons in their use of available resources and showing the effects of ecological, psychological, and biological factors on these patterns of decision making. ($232,848)

- The University of Illinois at Chicago Circle will conduct a national survey to provide detailed information on the needs of older people, particularly as these relate to social integration, community services, and health and specialized housing. ($112,246)

- The Institute for Research on Poverty, University of Wisconsin, will develop definitions of "adequate income level" for categoric groups of elderly, and descriptions of multiple factors, besides lack of income, which contribute to poverty in old age. ($19,926)

- The University of Southern California at San Diego will identify special characteristics of different aged minority groups which call for special types and methods of service programs. ($153,463)

- Case Western Reserve University, Cleveland, Ohio, will determine whether and to what extent certain economic and service incentives can induce and equip family units to provide home care for elderly members. ($78,838)

b. Model Projects in Aging

Section 308 of the Older Americans Act, as amended in 1973, authorizes the Commissioner on Aging, after consultation with the State Agency on Aging, to enter into contracts with or make grants to any public or nonprofit agency or organization within a State to pay part or all of the cost of developing or operating

Statewide, regional, metropolitan area, county, city or community model projects which will expand or improve social services or otherwise promote the well-being of older persons.

Four categories of services to Older Americans continued to be given priority for funding in FY 1975. They are housing and residential arrangements, with 11 projects funded at $721,860; continuing education, with 11 projects funded at $971,026; retirement preparation, adjustment, and opportunities for new roles, five projects funded at $507,252; and services for the physically and mentally impaired, seven projects funded at $1,065,154. Nineteen additional projects, with goals addressed to several priorities, were funded in the amount of $1,803,489. The latter adds impetus to comprehensiveness of service, which also characterizes the program development thrust of State and area agency planning and coordination, underscored in Section 303 of the Older Americans Act.

In addition, AoA launched two new Model Projects Program initiatives during FY 1975, directed toward developing and expanding legal services and a nursing home ombudsman service on behalf of older persons.

The legal services initiative is designed to inaugurate a process which will ultimately result in the inclusion of a legal services component within each of the comprehensive coordinated services structures being developed through the State and Area Agencies on Aging. Further, it is designed to initiate a process which will help insure that such legal services activities designed to meet the needs of older persons can be staffed with adequately trained professional and para-professional personnel. In FY 1975 the Model Projects in Aging Program provided support for 14 legal services projects for older persons, totaling $1,193,259.

The Nursing Home Ombudsman Program was initiated nationwide with projects in 47 States, the District of Columbia, and Puerto Rico, totaling $1,112,604. The grants are designed to help State Agencies on Aging to promote effective ombudsman activities at the State level and to develop the capabilities of the Area Agencies on Aging to promote, coordinate, monitor and assess nursing home ombudsman activities within their service areas. State and Area Agency personnel will work with government agencies, citizen's organizations and nursing home associations to develop mechanisms for receiving and resolving complaints made by or on behalf of nursing home patients and elderly residents of other long term care facilities, and to initiate systemic changes designed to improve quality of long term care for the elderly.

Examples of funded projects in each of the areas delineated above are briefly described below.

Housing

In the area of housing, the New England Non-Profit Housing Development Corporation is conducting a project to demonstrate improved ways of assisting public officials and community leaders in implementing a range of alternatives in the provision of improved housing for older persons. The project is based upon previous research and demonstration activities, and emphasizes the use of regional resources to accomplish objectives. In another housing project in Dade County, Florida, the United Home Care Services is conducting the project, "Share-A-Home," to assess the benefits of a shared home arrangement in meeting both housing and social needs.

Continuing Education

The National Association for Human Development will conduct a Model Project for Physical Fitness for older persons as one of the activities funded under the priority of continuing education.

Services for Physically and Mentally Impaired Elderly

In San Francisco, the Chinatown-North Beach Health Care Planning and Development Corporation has developed the ON-LOK Senior Health Services Model Project to assure needed services for the physically and mentally impaired elderly in that area. Another project to assist the frail elderly is a Model Dental Program for the Elderly, to be operated by the University of Oregon Model Dental Program in Portland, Oregon.

Multiple Priorities

In the category of projects addressed to multiple priorities, the Minnesota Consortium, sponsored by the College of St. Thomas in St. Paul, is developing new roles and improving on existing roles for educational insitutions in the field of aging. The project involves a vocational school, an elementary and secondary public school system, the state university, a state college, a community college and two private colleges. A broad range of activities is spanned, including curriculum development, training of paraprofessionals, community organization and technical assistance. Funding is also being provided to projects which address the special concerns of minority group elderly, including projects to be conducted by the Montana United Indian Association, the Gila River Indians in Arizona, the Inter-Tribal Council of Nevada and the Papago Council in Arizona.

Nursing Home Ombudsman

The State Agency on Aging in Colorado is implementing a statewide nursing home ombudsman program by utilizing the State, regional and local service and regulatory agency network that has been planned and developed over the last few years to deal with the complaints and problems of nursing home residents. Within this present network is the Senior Citizens Law Center, which, since October, 1974, has operated a nursing home advocacy project for more than 50 percent of the nursing home residents in the Metropolitan Denver region. The state-wide project builds on the existing project with the intent to expand its services to all of Colorado's 16,000 nursing home residents by further coordination and integration of its operations with the entire governmental agency network mentioned above.

In Tennessee, the State Agency on Aging is establishing the Tennessee Commission on Aging as the focal point for the promotion and development of statewide nursing home ombudsman activities. The program seeks to place a local representative in each nursing home within the program area for weekly visits to nursing home residents, to establish a local unit within each participating Area Agency on Aging with the capability to maintain a visitation network and to handle effectively complaints, and to gather information relative to the general nursing home situation within the program area which will be utilized by those interested in nursing home care in Tennessee.

Legal Services

The National Senior Citizens Law Center is conducting a project to provide legal service technical assistance to State and Area Agencies on Aging throughout the central and western portions of the nation. The Center is playing a major role in assisting these agencies to establish, develop, and expand an evolving network of legal service activities to serve the needs of older persons. Emphasis is being placed on assisting these agency staff to understand substantive aspects of the law in helping legal service providers to provide quality legal services to the elderly. The Legal Research and Services for the Elderly (LRSE) program of the National Council of Senior Citizens has received a Model Project grant to continue its efforts to assist in the development of local legal programs serving older persons. Programs are being developed through law schools, legal services agencies, bar associations, area agencies on aging and other organizations which focus on training of paralegals, direct counseling to elderly clients, consumer education, and training area agency and social service workers concerning the legal problems of elderly persons. LRSE is also available to assist State Agencies on Aging in such areas as advising them in the execution of their responsibilities under the Older Americans Act, identifying and researching key State legislative issues affecting the elderly, and drafting aging-related legislation.

The University of Michigan Law School is conducting a project to provide technical assistance to State and Area Agencies on Aging for the provision of legal services to the elderly through identification of potential legal resources and the development of various training materials and methodologies. These materials will heighten these agencies' ability to expand the involvement of the private bar, legal services, law schools, and continuing legal education organizations in the provision of legal services to older persons. While these materials are primarily designed for application in Michigan, the potential exists for their national application.

Progress has been made in the past year in developing national policy related to the needs of older people in natural disasters. The impetus for such national planning is an outgrowth of the experience of the four disaster-related projects supported during the previous year. Grant support was provided the State Agency on Aging in Nebraska in FY 1975 following the tornadoes which affected many older persons in Omaha. A more detailed discussion of these activities is presented in the discussion of Special Projects, near the end of this Report.

A complete listing of Model Projects awards follows on the next page.

5. TRAINING

Under Title IV, Part A of the Older Americans Act as amended, AoA is authorized to help meet critical shortages of adequately trained personnel for programs in aging by: (1) developing information on the actual needs for personnel to work in the field of aging, both present and long range; (2) providing a broad range of quality training and retraining opportunities, responsive to changing needs of programs in the field of aging; (3) attracting a greater number of qualified persons into the field of aging; and (4) helping make personnel training programs more responsive to the need for trained personnel in the field of aging.

The FY 1974 appropriation for Title IV, Part A was $9.5 million. Training grants are forward funded, so the activities taking place in FY 1975 were supported by funds awarded late in FY 1974. The following manpower and training activities were in progress in Fiscal Year 1975.

a. Career Education in Aging

The Administration on Aging supports training programs at institutions of higher education that will provide students with the necessary gerontological knowledge and skills to enable them to serve the Nation's elderly in their chosen career or profession. It is the intention of this program to stimulate the development of gerontological interest and expertise among the faculty and student body of these educational institutions, to assist in supporting the development of gerontological teaching capability, and to promote the development of an institutional commitment to gerontology and the field of aging. Through this career development program, at baccalaureate, masters, and doctorate levels, students are prepared for employment in State and Federal program planning and administration, community development and coordination, administration of retirement homes and homes for the aged, senior center direction, teaching and research, and for serving older people through adult education, architectural design, counseling, law, library service, recreation, and other relevant fields.

TABLE I

Model Projects on Aging

Housing

PROJECT TITLE	GRANTEE	AWARD
Housing Alternatives for New England Senior Citizens	New England Housing Development Corp. New Hampshire	68,000
Training Managers for Housing for the Elderly	National Center for Housing Management Washington, D.C.	142,431
Share-A-Home	United Home Care Services Miami, Florida	59,288
Vacation Residential Exchange Program for Low-Income Older Adults	International Center for Social Gerontology Washington, D.C.	51,830
International Information Clearinghouse Committee: Housing and Environments	International Center for Social Gerontology Washington, D.C.	123,174
Housing Rehabilitation and Repair Assistance for Low-Income Senior Citizens	Meridian Charter Township Okenos, Michigan	42,500
Statewide Model Projcet Program (Housing)	Trust Territories of the Pacific Islands, Office of the Commissioner, Saipan, Mariana Islands	125,000
Winterization of Homes Owned by the Older Citizens of Colorado	Colorado Congress of Senior Organization Denver, Colorado	50,000
Triangle J, AAA Housing Assistance Program	Triangle J Council Durham, North Carolina	28,637
Home Improvement Services for Older Americans	Emerson Jaycees, Emerson, Nebraska	11,000
Model Demonstration Housing Repair Project	Mid-Columbia Community Action Council The Dalles, Oregon	20,000

CONTINUING EDUCATION

Preventive Health Education for the Elderly	Urban Health Institute East Orange, New Jersey	$ 90,000
Minority Aged Services Training Inst.	National Urban League, New York	173,659
Project MISSILE	Rockland Community College, Suffern, N.Y.	84,899
Model Project for Physical Fitness	Nat'l Assoc. for Human Development Washington, D. C.	266,809
Interim Catalyst Program	Brevard Community College Coco, Florida	59,952
Special Information Services, T.V. Program for the Elderly	New York Office of the Aging New York	16,774
Retirement Planning and Counselling Program	Duke University, Durham, North Carolina	19,986
Uptown Elders Educational Program	Ecumenical Institute, Chicago, Ill.	25,000
Utilization of University Resources for Renewal and Redirection of the Abilities of the Retired	Governor's State University Park Forest, Illinois	54,420
Minnesota Consortium Educational Services in Retirement Planning for the Elderly	College of St. Thomas St. Paul, Minnesota	125,492
Arkansas College Consortium for Sixty Plus	Westark Community College Fort Smith, Arkansas	54,035

SPECIAL PROGRAMS FOR THE PHYSICALLY AND MENTALLY IMPAIRED

New Roles for the Elderly (Day Care)	Pennsylvania State University University Part, Penna.	$145,000
ON LOK Senior Health Services Model Project	Chinatown--North Beach Health Care Planning and Development Corp.	200,365
Direct Services to the Senior Citizens Community	City of Rockville, Rockville, Md.	50,903
T.R.I.P.-- West Virginia Department of Welfare	Charleston, West Virginia	400,000
Elderly Day Care Organized in Neighborhood	Case Western Reserve University Cleveland, Ohio	104,502
A Model Dental Program for the Elderly	University of Oregon Model Dental Program, Portland, Oregon	83,735
A Community-Based Program for Mentally Frail Elderly	New York City Office for the Aging	80,649

MULTIPLE PRIORITIES

Project Independence	Bureau of Maine's Elderly, Department of Health and Welfare, Augusta,	$165,995
Emergency Information and Referral Program	New York City Office for the Aging, New York, New York	80,379
Crime, Safety and the Senior Citizen	International Association of Chiefs of Police, Gaithersburg, Maryland	150,000
Regional Information and Referral Support System	United Way of Pinellas St. Petersburg, Florida Maine	70,000

TAP-XX	St. Louis Area Agency on Aging St. Louis, Missouri	$200,580
Mobile Information and Referral Unit	Southwest Missouri Area Agency on Aging, Springfield, Missouri	75,764
Elder Citizens Coalition of Washington	Elder Citizens Coalition of Washington, Inc., Seattle, Wash.	25,000
Comprehensive Geriatric Services Development Project	Geriatric Authority of Holyoke Holyoke, Massachusetts	69,812
Hand-in-Hand	Girl Scouts of America, New York, New York	108,088
Model Senior Citizens Service Lounges	Department of Human Resources Washington, D.C.	209,992
Technical Assistance to Synagogue Leadership for Programming Direct Services to Older Persons	Synagogue Council of America New York	68,780
Development of a Design for an Information and Referral System for the Elderly	South Carolina Commission on Aging Columbia, South Carolina	25,912
Lieutenant Governor's Ombudsman on Aging	Office of the Lieutenant Governor Springfield, Illinois	$ 73,820
Elderly Urban Indians	Montana United Indian Association Helena, Montana	83,000
ABRAZAR--LULAC	Phoenix, Arizona	156,994

The Wise Ones	Papago Council, Sells, Arizona	$ 56,039
Elderly Nutrition Program	Gila River Indians, Sacaton, Arizona	88,463
Food Delivery Service	Inter-Tribal Council of Nevada, Reno	77,371
TRIDENT	Kitsap County, Port Orchard, Wash.	17,500

RETIREMENT PREPARATION AND ADJUSTMENT

Regional Handicraft Industries	Handicraft Marketing Sales Washington, D.C.	$ 70,117
Project HEAL	Pima Council on Aging Tucson, Arizona	24,300
Clearinghouse for Voluntary Employment Agencies for Aging	Human Resources Center, New Life Institute, Albertson, New York	39,955
Project SARR	San Diego Ecology Center San Diego, California	22,488
Operation Independence	National Council on the Aging Washington, D.C.	350,000

LEGAL SERVICES

GRANTEE		AWARD
Tolland Windham Legal Services	Willimatic, Connecticut	$ 33,406
Presbyterian Senior Services	New York, New York	44,600
National Council of Senior Citizens	Washington, D.C.	249,607
National Paralegal Institute	Washington, D.C.	150,000
National Retired Teachers Association-American Association of Retired Persons	Washington, D.C.	85,000
University of Michigan	Ann Arbor, Michigan	91,032
Louisiana Center for the Public Interest	New Orleans, Louisiana	70,432
University of Southern California	Los Angeles, California	225,000
Senior Adult Legal Assistance	Palo Alto, California	47,322
California State Office on Aging	Sacramento, California	121,000
George Washington University	Washington, D.C.	75,860

NURSING HOME OMBUDSMAN

Grants to State Agencies on Aging

Region I

Connecticut	$18,000
Maine	18,000
Massachusetts	18,385
New Hampshire	18,000
Rhode Island	18,000
Vermont	18,000

Region II

New Jersey	$21,385
New York	57,931
Puerto Rico	18,000

Region III

Delaware	$18,000
District of Columbia	18,000
Maryland	18,000
Pennsylvania	38,188
Virginia	18,000
West Virginia	18,000

Region IV

Alabama	$18,000
Florida	30,608
Georgia	18,000
Kentucky	18,000
Mississippi	18,000
North Carolina	18,000
South Carolina	18,000
Tennessee	18,000

Region V

Illinois	$32,493
Indiana	18,000
Michigan	22,702
Minnesota	18,000
Ohio	29,574
Wisconsin	18,000

Region VI

Arkansas	$18,000
Louisiana	18,000
New Mexico	18,000
Texas	30,810

Region VII

Iowa	$18,000
Kansas	18,000
Missouri	18,000

Region VIII

Colorado	$18,000
Montana	18,000
North Dakota	18,000
South Dakota	18,000
Utah	18,000

Region IX

Arizona	$18,000
California	54,708
Hawaii	18,000
Nevada	18,000

Region X

Alaska	$18,000
Idaho	18,000
Oregon	18,000
Washington	18,000

For the 1974-75 academic year 35 educational institutions which supported career training programs in 1973-74 operated under one-year Title IV, Part A continuation grants. The funds were used primarily to support existing programs in gerontology, including student support based on need as determined by the university. Approximately 4600 students were enrolled in aging courses and programs at these AoA-supported training institutions; 625 of these students received financial assistance as part of the FY 1974 career training grant awards to the universities.

At the close of FY 1975, approximately $3.5 million was awarded on a national competitive basis to educational institutions to support career training programs. As a result of the national competition, 50 awards were made to 47 colleges and universities in 34 States for the conduct of career training activities during FY 1976 as follows:

University of Alabama	$ 50,039
University of Arizona	73,617
University of Arkansas at Little Rock	31,890
California State College, Sonoma	43,675
University of California Berkeley	25,122
Holy Names, Oakland	27,982
San Diego State University	89,923
University of S. California Dual Degree	125,029
University of S. California Environmental	76,609
University of S. California Summer Inst.	56,570
Adams State College	23,313
University of Connecticut	77,347
Federal City College	147,752
Howard University	48,901
University of S. Florida	30,231
Albany State College	15,118
Georgia State University	48,476
University of Hawaii	102,688
University of Chicago	135,900
Wichita State University	93,199
Southern University, New Orleans	50,693
University of Maine, Portland	34,750
Antioch College, Columbia, Maryland	43,272
University of Maryland	40,200
Boston University (Consortium)	154,837
University of Michigan	239,729
University of Minnesota	96,674
University of S. Mississippi	35,902
University of Missouri	86,412
St. Louis University	90,226
Kansas City Regional Council for Higher Education	116,853
University of Nebraska, Omaha	82,632
Fairleigh Dickinson	51,198
Syracuse University	139,172
Livingstone College	32,900
Bowling Green State University	51,606
Miami University	30,241
University of Oregon (Consortium)	228,689
Portland State University	74,042
Pennsylvania State University (summer)	26,385
Pennsylvania State University	143,550
Fisk University	80,607
Bishop College	27,632
North Texas State University	25,015
Our Lady of the Lake	54,066

University of Utah (Consortium)	219,508
University of Washington	79,579
University of West Virginia	51,724
University of Wisconsin-Madison	72,429
University of Wyoming	16,088

b. In-Service Training

AoA has supported a number of short-term intensive training programs which have provided skills to several thousand persons recruited from all parts of the country. With the implementation of Titles III and VII a great many newcomers, requiring such training programs, have been attracted to the field of gerontology. Moreover, upgrading of competencies has been required for many persons who were already in the field of aging prior to the passage of the 1973 Amendments to the Older Americans Act, given the new program responsibilities created under that legislation. During FY 1975 support for in-service training was expanded to meet these needs. Examples of these training activities include the following:

> Syracuse University developed a series of State Leadership Conferences and trained State Agency Executives and key staff in leadership roles and responsibilities deriving from the broad mandate of Title III as it now reads.
>
> The Assistance Group Inc. of Silver Spring, Maryland trained, during FY 1975, approximately 75 State Agency personnel in techniques of providing technical assistance to persons at State and local agencies who are responsible for meeting the Administration on Aging's requirements for information and referral programs.
>
> Ten colleges and universities conducted symposia for faculty members and others offering courses related to the needs of older persons. The symposia presented current information on training materials and methods as well as information related to programs under the Older Americans Act.

To supplement the short-term training activities undertaken to upgrade the competencies of State and Area Agency personnel and nutrition project staff, $4.0 million of FY 1974 funds were awarded in June 1974 to State Agencies on Aging to be used by them in meeting FY 1975 State and local training and manpower development needs not addressed by the national training efforts, but necessary for effective implementation of the 1973 Amendments. Late in FY 1975, $3.5 million was awarded to State Agencies on Aging to continue during FY 1976 the support of training which meets the priority in-service needs identified for State and Area Agency personnel. State Agencies were encouraged to work with post secondary educational institutions serving planning and service areas with established area agencies on aging in the development and delivery of training courses. The FY 1975 grants to State Agencies on Aging are listed below:

Alabama	$ 54,818
Alaska	20,000
Arizona	29,273
Arkansas	38,592
California	295,910
Colorado	30,918
Connecticut	$ 47,473
Delaware	20,000
District of Columbia	20,000
Florida	165,552
Georgia	63,041
Hawaii	20,000
Idaho	20,000
Illinois	175,748
Indiana	78,939

Iowa	53,174
Kansas	41,114
Kentucky	54,161
Louisiana	51,529
Maine	20,000
Maryland	51,529
Massachusetts	99,441
Michigan	122,793
Minnesota	63,370
Mississippi	36,509
Missouri	87,709
Montana	20,000
Nebraska	28,067
Nevada	20,000
New Hampshire	20,000
New Jersey	115,667
New Mexico	20,000
New York	313,343
North Carolina	71,812
North Dakota	20,000
Ohio	159,960
Oklahoma	48,420
Oregon	37,277
Pennsylvania	206,556
Rhode Island	20,000
South Carolina	33,768
South Dakota	20,000
Tennessee	64,247
Texas	166,648
Utah	20,000
Vermont	20,000
Virginia	62,603
Washington	52,406
West Virginia	31,865
Wisconsin	74,772
Wyoming	20,000
American Samoa	10,000
Guam	10,000
Puerto Rico	31,356
Trust Territory	10,000
Virgin Islands	10,000

e. Manpower Development

As part of the plans for implementing its responsibilities under Section 402 of the Older Americans Act, the Administration on Aging in FY 1974 entered into a joint agreement with the Bureau of Labor Statistics, Department of Labor to assist in developing information on manpower needs in the field of aging.

During FY 1975 the Bureau of Labor Statistics completed a study entitled "Manpower Needs in the Field of Aging: The Nursing Home Industry." This study presents an analysis of the manpower needs of nursing homes as well as an analysis of future supply - demand conditions for several key occupations in the nursing home industry. This document has been printed and is available for distribution from the Administration on Aging.

Future studies are being planned that will be devoted to the occupational outlook of a specific industry or occupational field of high priority concern to older persons. As these studies are completed they will be disseminated as part of a series of technical papers that will be available to researchers, educators, practitioners and students in gerontology and related fields.

In further support of its responsibilities under Section 402, AoA began formulating plans to conduct public hearings designed to generate information on manpower needs in the field of aging. These hearings will be held during the spring of 1976.

The Older American Comprehensive Services Amendments of 1973 direct the Commissioner on Aging to support activities designed to attract a greater number of qualified persons into the field of aging. Young people enrolled in high schools, vocational and technical schools, colleges, and universities are more likely to plan and prepare for careers in the field of aging if they are aware of the career opportunities available. Recognizing the absence of vocational guidance materials that provide information on current and projected future job opportunities in the field of aging and related guidance information, the Administration on Aging has asked the Bureau of Labor Statistics to develop and disseminate vocational guidance materials that discuss careers in the field of aging. The information developed will be presented in a format consistent with vocational guidance materials currently published by the BLS and will be published in the Fall of 1976 with a special issue of the Occupational Outlook Quarterly that will be devoted exclusively to the field of aging.

Other grants made by AoA with FY 1975 funds are for the development of improved curriculum, and to stimulate interest in second careers in the field of aging. Awards made include the following:

"Second Careers - New Opportunities in Allied Health" George Washington University	$121,219
"Design Education - Resources Development in Environments and Aging" Gerontological Society	$101,450
"Training Older Adults in Community Organization and Development in Aging" University of Washington	$26,824
"Development Education Models" Duke University	$64,728
"National American Indian Training Program" Association of American Indian Social Workers	$84,084
"Use of Video in Gerontology Courses" University of Maryland	$55,027

d. Conferences

Support for national conferences was provided by AoA to initiate new developments in the field of aging, and to share nationally the knowledge gained from research, demonstrations, and significant experience. The following awards were made in FY 1975 for conferences:

"Image Conference on Aging" Department of Elder Affairs State of Massachusetts	$11,000
"Development of Model State Legislation in Aging" The Council of State Governments	$112,514
"U.S. Project on the Elderly" U.S. Conference of Mayors	$188,988
"Gerontology as a New Frontier in Higher Education" Association for Gerontology in Higher Education	$4,995

"Seminar on the Care and Needs of Elderly Mentally Ill in Nursing Homes and Board and Care Homes" American Psychiatric Association $17,501

"Central Conference of American Rabbis Conferernce on Aging and Planning for Retirement" Central Conference of American Rabbis $5,000

"Youth Conferences on New Charter for Older Americans" National Retired Teachers Association/American Association of Retired Persons $39,800

6. EVALUATION

The FY 1975 Evaluation Plan stresses the evaluation of the major AoA program activities: the Area Planning and Services Program, Nutrition Program for the Elderly, and Information and Referral. Contracts for these evaluations will be let in the first quarter of FY 1976. (Contract awards were delayed due to limitations on contracts included in the FY 1975 DHEW/DoL Appropriations Act.) In addition, AoA is co-sponsoring the SRS evaluation of the Title XX Program.

The following new projects will begin in early FY 1976:

(a.) Longitudinal Evaluation of the Nutrition Program

AoA published a request for proposals for this evaluation based on a methodology previously pilot-tested under contract by AoA. The contract was awarded to Opinion Research Corporation of Princeton, N.J. with Kirschner Associates, Incorporated as sub-contractor. The evaluation study will attempt to measure the impact of the program in terms of its effect on the health status, nutritional status, isolation, life satisfaction, longevity, and institutionalization of the participants. It will also determine the relationship of these impacts to nutrition project characteristics and policies in order to recommend improvements.

(b.) Area Planning and Services Program Evaluation

Based upon in-house research and information collected by the National Bureau of Standards, AoA developed a methodology for the evaluation of the organizational effects of Area Agencies on Aging. A request for proposals was published and Westat, Inc. of Rockville, Md. was selected to perform this evaluation. Ecosometrics, Inc. of Bethesda, Md. and Robert Walker and Associates of Minneapolis, Minn. will serve as subcontractors. This study will attempt to measure changes in older persons resulting from the efforts of Area Agencies on Aging.

(d.) I&R Evaluation

AoA has required that I&R services be available and assessible to every older person. AoA signed a contract with Mark Battle Associates of Washington, D.C. to measure the progress of State and Area Agencies on Aging in developing the elements and components of I&R services consistant with AoA guidelines for such services.

(e.) Title XX Evaluation

Title XX is a major potential source of funds for services to older persons. AoA is co-funding with SRS the first major evaluation of this new program. The evaluation will study both the effect of the program on older persons and the involvement of State and Area Agencies on Aging in the Title XX planning process.

The following projects were completed in FY 1975:

(a.) Older Americans Status and Needs Assessment Survey System

The Older Americans Status and Needs Assessment Survey for use by State and Area Agencies has been completed and distributed. The package included a pretested survey form, survey manual, interviewer training manual and a utilization manual. The utilization manual discusses use of the data collected for public relations, legislative relations, planning, evaluation, and coordination.

(b.) Secondary Data Manual:

A manual describing sources and uses of secondary data, such as census reports, for use in planning by State and Area Agencies was developed and will be distributed with the Status and Needs Assessment Survey.

(c.) Evaluation and Monitoring Tools for Area Agencies on Aging:

Three self-evaluation and monitoring tools were disseminated to State and Area Agencies on Aging. The tools deal with the following areas:

a. self-assessment of basic functions and preparation for the State assessments;

b. evaluation of existing service providers' capacity;

c. evaluation and monitoring of service providers with whom the area agencies have agreements or contracts;

Each of these tools was pretested in five Area Agencies on Aging in order to determine its applicability and ease of performance. State Agency and Regional Office staffs were trained in their use. These tools provide optional technical assistance.

(d.) Systematic Review of Area Agencies on Aging:

The systematic review of Area Agencies on Aging involved the collection and analysis of data on those agencies. Data relevant to agency type, funding level, staff size, planning and service area demographic characteristics, etc. were collected from Regional Offices. The data were organized and aggregated and the resulting printouts for each State in their region were provided to the Regional Offices.

The following studies are in progress:

(a.) Nutrition Outreach Evaluation: This evaluation is measuring the effectiveness of the nutrition projects in reaching and serving those most in need of nutritional services including the minority, impaired and isolated elderly. The report is due in fall 1976.

(b.) Strategy Evaluation for the National Clearinghouse on Aging: This project will produce a strategy for establishing the National Clearinghouse. It will survey potential Clearinghouse users and sources of information as a basis for the strategy. The project report will be provided in summer 1975.

(c.) R&D Utilization Evaluation: This project is collecting information on highly utilized and poorly utilized R&D projects in an attempt to determine the internal and external variables which have affected the utilization of the results. Both project directors and potential users of project findings were surveyed. The final report is due in late summer 1975.

(d.) State Agency Evaluation: This project is using the structured case study approach to evaluate the effectiveness of State Agencies on Aging in terms of their planning, coordination, assessment, advocacy and technical assistance functions. It is also studying SSI Alert. Fifteen State Agencies have been studied and both qualitative and quantitative information collected. The report of the study will be completed in fall 1975.

(e.) Evaluation and Monitoring Tools for the Nutrition Projects: This project will produce several tools which may be used by nutrition project directors including a combined guide for a site assessment and preparation for State assessments, a former participant questionnaire, a home delivered meals assessment guide, a food service contract monitoring tool, and a community food preparation costs comparison tool. These optional technical assistance tools will be distributed in summer, 1976.

(f.) AoA Data Base: Documentation Associates of Los Angeles California, under AoA contract, collected documents containing data on the minority elderly and services to older persons for the AoA Data Base. These data will complement the existing collection of statistical data on two of AoA's priority target groups: the low-income elderly and the impaired, noninstitutionalized elderly. The documents will be indexed and a retrieval system developed to allow the user to locate relevant references. Also develeoped under this contract is a thesaurus of terms covering the field of gerontology. Publication of contract products is planned in early FY'76. This thesaurus will be of use to all professionals in the field of gerontology. Further information on the Data Base is contained in Section 7 of this report.

(g.) Social Statistics System for the Elderly: The Census Use Study Group of the Bureau of the Census is developing a social statistics system for use by State Agencies on Aging. The system will utilize existing data from various sources, organize the data and allow analysis of the data in order to determine the status and needs of the elderly. A prototype system is being developed for Nebraska. A handbook including complete instructions will be provided to allow duplication of the prototype system by other State Agencies who elect to do so. A report discussing the Nebraska experience will also be published.

A feasibility study for a similar system for use by Area Agencies on Aging was performed. The study report is being reviewed by Area Agencies to determine if that system should be developed.

(h.) Evaluation of Aging Magazine: An in-house evaluation is being conducted to assess Aging, a magazine published by AoA's National Clearinghouse on Aging.

(i.) Evaluation of Alternatives to Institutional Care (Co-sponsored With SRS): Work is underway to develop a study methodology through the use of sample surveys to determine costs and impact of various forms of long-term care in both community and institutional settings. The methodological approach is being developed as part of the Older Americans Resources and Services (OARS) study at Duke University in North Carolina. A national study is being considered for funding in FY'76.

7. NATIONAL CLEARINGHOUSE ON AGING

The organizational structure of the National Clearinghouse on Aging has been modified somewhat since FY 1974. The Clearinghouse is now composed of the Office of the Director, plus a small Information and Referral Policy Staff within that office and three distinct but interrelated units as opposed to the four named in the FY 1974 Annual Report. These units are: Public Information, Data Analysis and Dissemination, and Public Inquiries and Publications Distribution.

The Clearinghouse is charged with collecting, analyzing and disseminating information about the elderly and their needs; providing information to agencies and organizations concerning programs for the aging; encouraging the establishment of State and area information and referral services to meet the needs of the elderly population; and stimulating other agencies to prepare and disseminate information for the field. In addition, one of the most important functions of the Clearinghouse is its consumer information service. The Office of Consumer Affairs, the Consumer Products Information Center, and NCA work in concert on the distribution of selected publications dealing with consumer problems.

Activities carried out by the Clearinghouse in FY 1975 and at present are supported through the use of S&E funds allocated to AoA. Certain studies supportive of Clearinghouse activities are supported from evaluation funds.

a. Information and Referral

A requirement set forth in the Older Americans Comprehensive Services Amendments of 1973 and related regulations is that State and Area Agencies on Aging must ensure that all older people shall have reasonably convenient access to information and referral services by June 30, 1975. These information and referral efforts will help link older persons with opportunities, resources, and services that enable them to meet their needs and enhance the meaning of their later years. Information and referral services also aid in the collection and reporting of information about the needs of older people and the adequacy of resources available to them. Viewed in these terms, an information and referral service becomes a cornerstone for building comprehensive, coordinated service systems for older people.

Assisting State and Area Agencies in launching new or improving existing information and referral services has become a major AoA activity. The primary responsibility for developing information and referral data and policy procedures is lodged in the National Clearinghouse on Aging, which works closely with the Office of State and Community Programs in its efforts to implement the statutory requirement.

(1) Technical Assistance and Guidelines to State and Area Agencies

Agencies providing information or information and referral (I&R) services have been increasing in recent years. During Fiscal Year 1975, State and Area Agencies fostered expansion of I&R facilities and the extension of their services to older people. Simultaneously, the Administration on Aging continued to accumulate information about the operation and delivery of information and referral services to share with State and Area Agencies on Aging.

To assist State and Area Agencies in evaluating existing information and referral services and fostering their establishment where they do not exist, the Administration on Aging issued a Program Instruction specifying minimum elements of an I&R service to be in place by June 30, 1975, and an Information Memorandum identifying suggested long range goals toward which State and Area Agencies on Aging should work in the progressive development of these services. In the development of these issuances, considerable weight was given to the findings of research and demonstration projects on information and referral services supported by the Administration on Aging and other agencies, as well as to operational experience in this area. Standards for these services promulgated by national voluntary organizations were also given consideration.

To support further State and Area Agencies in meeting their I&R requirements, AoA provided training to personnel of State Agencies on Aging in planning, developing and evaluating I&R services which meet the Administration on Aging requirements. Three consecutive four day training sessions were held in Philadelphia, Chicago, and San Francisco during the month of February, 1975.

(2) Interdepartmental Cooperation

During FY 1975, the Administration on Aging, working with an Interdepartmental Task Force on Aging, negotiated a joint working agreement among 15 departments and agencies having responsibility in the I&R field and an intradepartmental agreement involving the Social Security Administration, the Social and Rehabilitation Service, and the Administration on Aging. These agreements are also discussed earlier in this report under "Federal Coordination Activities."

The task force worked under the aegis of the Interdepartmental Working Group on Aging created by the Committee on Aging of the Domestic Council. The objectives of the agreements are: (1) to extend and coordinate the efforts of the participating departments and agencies in the I&R field and (2) to encourage their counterparts in States and communities to cooperate in making I&R services immediately available to older people.

In May of 1975, the agreements were transmitted to the regional offices of all participating agencies. AoA program directors in the regions were asked to set up interagency task forces to foster appropriate activities of regional, State, and area levels, and to monitor and evaluate progress in achieving the stated objectives. In the 10 regional office cities, the AoA program directors have the assistance of members of the Federal Regional Councils and the Federal Executive Boards. In 15 additional cities, Federal Executive Boards are assisting Area Agency on Aging executives in the extension and improvement of I&R services. The section of this report on "Federal Coordination Activities" provides more details on the I&R activities of Federal Executive Boards.

(3) Grants and Contracts of National Scope

To obtain information pertinent to the I&R field in general, the Administration on Aging made a number of contracts and grants during 1974 which will document and assess I&R systems, investigate the cost effectiveness of I&R systems serving older people exclusively with that of I&R systems serving people of all ages. The results of these studies are expected to become available during FY 1976 and will be shared with the AoA network and with others in the I&R field.

b. Public Information

(1) Public Information Support for the Field

A major objective of the National Clearinghouse on Aging during fiscal year 1975 was to provide improved public information support to the Regional Offices on Aging and State and Area Agencies on Aging. Toward this end the Public Information Division developed and printed an AoA Technical Assistance document entitled Public Information Activities for State and Area Agencies on Aging.

The publication provided suggestions on establishing good relationships with media personnel, the tools needed to deal with media, how to prepare materials for the press and for television and radio stations, tips on appearing on television, and how to conduct news conferences and how to hold public hearings on annual plans.

In November, a pilot communications conference was held in Columbus, Ohio, sponsored by the Administration on Aging, the Ohio Commission on Aging, and the Academy for Contemporary Problems. The purpose of the conference was to stress the need for coordinated planning and action among government and non-government agencies that serve older people and to outline ways to improve communications among these units. Tapes of portions of the conference were distributed to the 10 Regional Offices on Aging for use in planning similar conferences in other States.

During the spring two television and eight radio public service announcements on information and referral were developed under contract for distribution to State and Area Agencies on Aging. Jack Albertson of "Chico and the Man" was filmed for the TV spots. Four of the radio spots were in English and four were Spanish translations. The State and area agencies were urged to provide the spots to TV and radio stations in their areas along with the local telephone numbers of information and referral sources in their areas.

(2) TV Series on Aging

A 10-part television series on aging was produced by AoA in association with WRC-TV, Washington, D.C., for showing on NBC-owned stations. The ten 30-minute programs were aired in Washington, D.C., Cleveland, New York City, Los Angeles, and Chicago during the fall and winter 1974-75.

The series examined attitudes toward aging and problems faced by older Americans, and indicated services designed to help older people live more independent and rewarding lives. It was moderated by Bertha S. Adkins, Chairman of the Federal Council on the Aging, and it featured guests from Congress, Federal, State and local agencies on aging, as well as representatives from national organizations, universities, and non-profit agencies concerned with older people.

(3) Major Publications

Eight issues of *Aging*, the official publication of the Administration on Aging and its National Clearinghouse on Aging, were published during FY 1975. The current press run is about 18,000 copies per issue.

Aging is a newsmagazine intended for readers working for and with older Americans in many types of programs, particularly those conducted under provision of the Older Americans Act by AoA and its affiliated State and Area Agencies on Aging. It also has a limited foreign circulation among gerontologists. The magazine publishes news of innovative developments here and abroad in the field of gerontology, as well as aging-related programs proposed by the Executive and Legislative branches of the Federal Government, legislation enacted by the Congress dealing with aging, and aging-related reports by many public and private organizations. The newsmagazine's publications section regularly lists and reviews pertinent works.

During FY 1975 *Aging* adopted a new feature on its inside back cover: a chart containing an up-to-date listing of the status of bills pending in Congress which affect older Americans.

The May 1975 Older Americans Month issue contained a special 15-page section describing programs and activities of the Administration on Aging, for which there has been a large and continuing demand.

The booklet *To Find the Way to Services in Your Community* was rewritten with updated material and renamed *To Find the Way to Opportunities and Services for Older Americans*. An updated Spanish translation of the booklet has also been published.

In addition to fact sheets and press releases, other publications produced during the year included:

Older Americans and Community Colleges: An Overview - a directory of community colleges with programs in the field of aging, prepared by the American Association of Community and Junior Colleges as part of a training project funded by AoA.

Transportation for the Elderly: The State of the Art - the report to Congress on transportation required by Section 412(a) of the Older Americans Act, as amended in 1973.

Report to the President: Federal Council on the Aging

Older Americans Act of 1965, as Amended

(4) Bicentennial Exhibit

A Bicentennial exhibit, planned in 1974, was constructed during FY 1975 for installation in a booth in the new HEW building. The subject of the exhibit was the State and Community Grants Program, funded under Title III of the Older Americans Act, and administered by AoA. Emphasis was placed on the roles of area agencies on aging throughout the United States and its territories in encouraging the establishment of comprehensive coordinated systems of services to help older Americans maintain their independence as long as possible.

The exhibit includes a large wall plaque reproducing the "Declaration of Objectives for Older Americans" from the Older Americans Act, a slide-sound show explaining the exhibit and the purpose of the area agencies, a map showing all planning and service areas, and bins keyed to the map providing address cards. A number of AoA publications are also provided as pick-ups for visitors.

(5) Freedom of Information

The Freedom of Information (FOI) function, newly added as an additional function for the Public Information Division, resulted in several major tasks in the last few months of the fiscal year.

Besides several requests for advice on handling FOI requests, maintenance of file material under FOI, and an average of four to six requests a week for assistance on interpretation of regulations, there were several major requests for information under FOI.

All FOI requests have been answered well within the required 10-day working period.

c. Data Analysis and Dissemination

In FY 1975 AoA continued to provide a variety of statistical information to planners, program administrators, researchers, and others within governmental agencies at all levels and to personnel of non-governmental organizations. In addition, steps were taken to expand the existing collection of data and to develop a Thesaurus.

(1) The Information Center

Contracts were renewed through the use of evaluation funds to extend the data base and to undertake the development of a Thesaurus. The data base has been expanded to include information on the minority elderly and services to the general elderly population. Initially it included only data on the low-income and impaired non-institutionalized elderly. The Thesaurus will be used to index and retrieve material in the data base as well as to provide a standardized vocabulary in the field of aging. Two surveys were completed under contract. One to identify data base user needs and the other to ascertain available information resources.

(2) Provision of Statistical Data

During FY 1975, several publications were completed. Additional reports in the Facts and Figures on Older Americans series were issued. They include:

Number 10. Cumulative Index to Facts and Figures on Older Americans, Numbers 1 through 9

Number 11. Income and Poverty in 1973

Two new items were added to the Statistical Memorandum series. These were No. 30, BLS Retired Couple's Budget, Autumn 1973 and No. 31, Estimates of the Size and Characteristics of the Older Population in 1974 and Projections to the Year 2000.

An article based on Statistical Memo No. 31 was included in the June-July issue of AGING Magazine. Included with the article was a presentation of charts and graphs representing the growth and distribution by age, sex and race of the elderly population.

The statistical brochure New Facts About Older Americans, which contains a statistical profile of the elderly, has been updated and retitled Facts About Older Americans: 1975.

A contract was executed with the Census Bureau which would provide AoA with a count count of persons 65 years of age and older by county. The data, along with estimates of persons 60 years and over, are to be sent to the State and Area Agencies on Aging to assist them in formulating their plans and carrying out their advocacy functions.

(3) Response to Specific Requests

AoA responded to numerous requests for demographic, financial, and other data about the older population. Requests came from public agencies at Federal, State, and local levels and from nonprofit and profit private organizations. Data were sought for purposes of research, planning, program administration, evaluation and education.

Several requests came from the Senate Special Committee on Aging, the House Ways and Means Committee, and other legislative committees.

d. Public Inquiries and Publications Distribution

During Fiscal Year 1975 the Public Inquiries and Publications Distribution unit prepared 2,122 letters in response to a broad range of inquiries concerning needs of older persons in such areas as transportation, social services, housing, health care, senior centers, income-security, nutrition, legal services, employment, volunteer opportunities, and consumer protection. A number of inquiries and comments were received concerning the effect on older persons of current economic problems. Many of these inquiries are forwarded by Congressional offices, the White House, and Federal Agencies, as well as private organizations, older people and persons working in the field of aging.

In addition, over 7,800 telephone calls were responded to and a number of visitors were given assistance and information.

During the year AoA distributed 524,718 copies of publications addressed to older people and to personnel of agencies serving the older population. Many of these go out with letters in response to inquiries; the majority are distributed in response to direct requests from individuals or from organizations for subsequent distribution at meetings and conferences. Bulk orders are distributed by the Office of Human Development's Publication Distribution Center. Most of AoA's publications are also sold by the Superintendent of Documents.

There has been a sizeable increase in public inquiries over the past year. The increase is reflected as follows - 33% in letters, 160% in telephone calls and 8% in publication requests. The nature of the increased public inquiries reveals a heightened interest in the circumstances of older people, and in improving living conditions for them.

The Administration on Aging effected an agreement with the Senate's Special Committee on Aging whereby the Committee sends its publications which are relevant to the work of Regional and State executives in aging to them directly and provides copies to AoA which, in turn, makes distributions to Area Agencies on Aging.

8. SPECIAL PROJECTS

a. AoA Role in Disaster Planning Programs

During the year the Administration on Aging continued to be involved in disaster preparedness planning and disaster follow-up activities, utilizing the Regional Offices of Aging, State and Area Agencies on Aging and Title VII Nutrition Projects. Much of this effort was based on the experiences of AoA following Hurricane Agnes and the tornadoes which swept across the midwest and southeast in 1972 and 1974 respectively, and on the recommendations and framework established by the AoA disaster preparedness planning conference held in December, 1974.

Following up on the recommendations of the conference, AoA pursued the possibility of a mission assignment from the Federal Disaster Assistance Administration (FDAA) so that the national aging network could quickly respond with an assurance of financial reimbursement in disaster situations. FDAA for various reasons deemed this request inadvisable on a national basis, and, as an alternative, AoA is currently pursuing joint agreements/working arrangements with FDAA, the American National Red Cross, the National Institute of Mental Health, American Bar Association and other disaster relief agencies to insure that the special needs of older disaster victims are addressed.

The Administration on Aging has continued to respons to disasters affecting older persons, whether Presidentially declared emergencies or not. The AoA efforts in establishment of the disaster assistance network to assist older victims have resulted in "hot-line" communications between Central and Regional Offices as soon as word has been received of a disaster. Prompt alerting of State and Area Agencies has become nearly automatic in order to determine the extent to which older persons are affected, the magnitude of their short and long-range needs, and to see that linkages are immediately effected with available disaster assistance.

During the year, AoA has worked with nine Regional Offices of Aging and, through them, with 25 State Agencies on Aging on disaster relief activities caused by floods, fires, tornadoes, a hurricane and a volcano. The most extensive damage and effect on older persons was experienced in Omaha, Nebraska, which was struck by a tornado in May. The Region VII Office of Aging, the Nebraska State Commission on Aging and the Omaha Area Agency on Aging, immediately responded with an extensive outreach program which identified several hundred older persons who were affected by the tornado.

AoA funded a model project to assist the Omaha Area Agency on Aging in responding to needs and documenting the steps followed in providing disaster relief assistance. Chore services nutrition services, transportation services and legal aid were made available within five days after the tornado struck. The services to the elderly were immediately incorporated into the official disaster assistance operation, with long-range follow-up built into the program.

Under the model project grant, the Nebraska State Commission and the University of Nebraska at Omaha at the end of FY 1975 were planning to work with the Region VII Office of Aging on the production of materials of use to other State Agencies in disaster preparedness planning. A conference on planning for post-disaster services was projected for early 1976, if the materials warranted.

b. SSI-Alert Activities

Although the Administration on Aging did not fund any additional SSI-Alert projects during 1975, the impetus and some funding during the latter part of 1974 carried into 1975. Consequently a number of Area Agencies on Aging included in their outreach efforts the locating of potential SSI recipients and made referrals to the Social Security Administration.

Carry-over funds in three States served by Region VII were being considered for possible SSI-Alert outreach on Indian reservations, under the Office of Aging leadership. At the end of the fiscal year, one SSI-Alert project had begun at the Wind River Reservation in Wyoming. Four outreach workers had made 450 contacts and completed 210 lead forms. Preliminary checking by Social Security showed 74 of the 210 were already receiving SSI, 64 were potentially eligible, and 40 were already receiving Social Security benefits.

The Administration on Aging has also continued to work with the Social Security Administration in the latter's efforts to develop additional outreach activities to find potentially eligible SSI recipients.

Bicentennial Program in Aging

The Commissioner suggested during the spring that consideration be given by older Americans to an up-dating of the declaration of rights and obligations set forth in the Senior Citizens' Charter written during the 1961 White House Conference on Aging. The suggested process was for Advisory Committees to State Agencies on Aging and Advisory Committees to Area Agencies on Aging to conduct Older American Bicentennial Forums beginning in May, Older Americans Month.

The President in proclaiming Older Americans Month supported the Bicentennial effort. He wrote - "I urge everyone to participate in the efforts to achieve the goal of proclaiming a new Declaration of Rights and Obligations for Older Persons, which can become a rallying point for our Nation during the Bicentennial year of 1976 and a guide to action during the years ahead."

B. REHABILITATION SERVICES ADMINISTRATION

The major goal of the Rehabilitation Services Administration's program for the Aging is to rehabilitate as many older handicapped individuals as possible into gainful employment through activities of the State-Federal rehabilitation program administered by the agency.

The State Rehabilitation agencies endeavor to assist each individual to reach his most adequate functioning level and highest vocational potential. This is accomplished through a diagnosis of his condition followed by various services designed to overcome his specific handicap. Throughout the process, the emphasis is on helping the individual to help himself. These services include; evaluation and medical diagnosis to determine the nature and extent of the disability to ascertain capacity for work; counseling to help in developing a good vocational plan; medical care to reduce or remove the disability; vocational training and placement into employment; and follow-up to ensure satisfactory placement.

The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities and projects and will continue to do so. A Cooperative Agreement has been established between the Administration on Aging and the Rehabilitation Services Administration, which is designed to bring about improved coordination between the resources of the State-Federal program of vocational rehabilitation and the resources available under provisions of the Older Americans Act of 1965, as amended.

Recently three Expansion grants focused on rehabilitation of the aged disabled on, or near, the poverty level into employment. Public Welfare recipients were also included in this grouping. These projects were located in New York, Illinois and Massachusetts.

The aging handicapped receive particular attention in Section 304 of the Rehabilitation Act, which cites the older blind as an appropriate target population for the special projects authorized under that section of the Act. In 1976, projects designed to expand and improve rehabilitation services for blind people who are at least 55 years of age are being supported by this grant program in Arkansas, Colorado, Oregon, Texas, Virginia and West Virginia.

The Rehabilitation Services Administration coordinates with the Social Security Administration in utilizing the Social Security disability applicant load as an important referral source of older disabled persons for State vocational rehabilitation services.

It is estimated that there are over 4 million people 45 years of age and over eligible for, and in need of, rehabilitation services, of whom nearly one million are aged 65 and beyond. In an effort to alleviate this situation, State rehabilitation agencies have been intensifying their efforts to serve aging handicapped. As shown by the table below, it is estimated that of the total number of persons rehabilitated into employment in FY 76, 18% will be 45 years of age and over, and of those rehabilitants aged 45+, 10% will be 65 years of age and beyond.

Rehabilitated persons 45 years of age and over, and 65 years of age and over

Fiscal Year Ending June 30	All Rehabilitants	45 years of age and over	65 years of age and over
1973	360,726	74,164	5,069
1974	361,138	76,200 1/	6,500 1/
1975	324,039	63,500 1/	5,200 1/
1976 1/	312,000 1/	61,500 1/	6,000 1/
1977 1/	339,000 1/	60,700 1/	6,000 1/

1/ Estimate

C. OFFICE OF NATIVE AMERICAN PROGRAMS

C. The Office of Native American Programs, under its new legislation, P.L. 93-644, the Community Services Act of 1974, was extended under Title VIII, "The Native American Program Act of 1974" for the purpose of promoting the goal of economic and social self-sufficiency for Native Americans while recognizing the special and complex relationship existing between the Federal Government and Indian people and the issues and conditions unique to this vulnerable target group.

Under the new legislation, the long-range goal for the Native Americans Programs are (1) to develop the capacity of Native Americans and organizations to focus on planning as the basic method to improve resource allocations and effectiveness of services in Native American communities; (2) to achieve the development of the necessary social and economic infrastructure in Native American communities to increase self-sufficiency, and (3) to eliminate the most critical gaps in the range of social and human development services necessary for self-sufficiency.

Currently, the grants and contracts are not specifically oriented toward serving elderly Indians, although, of course, the elderly Indian is part of the service population with all other Indians residing in the community.

In FY 1976 the Office of Native American Programs entered into an intra-agency agreement with Administration on Aging to do basic data gathering research on the elderly Native American population.

D. OFFICE OF RURAL DEVELOPMENT

The Office of Rural Development was established by Secretary Weinberger in June, 1973 for the purpose of "catalyzing and institutionalizing throughout HEW a concern for meeting the needs of rural Americans." The Office recognizes that the elderly comprised a partioularly important group in rural areas. Although the elderly comprise ten percent of U.S. population in 1970, they made up approximately sixteen percent of all Americans living in non-metropolitan areas. Nearly one-third of these rural elderly live in poverty.

The Office is not an operating agency and has no program budget. Instead it is organized to impact on institutional processes of HEW which may improve the use of the Department's resources for delivering human services to rural residents. Examples of such processes include: intergovernmental relations, intradepartmental coordination, policy development, information sharing and capacity building through training and technical assistance.

The Secretary's mandate to the Office covers four specific areas of activity:

- To identify barriers to the delivery of HEW services in non-metropolitan areas;
- To design and recommend human service delivery systems for rural areas;
- To establish an internal network and coordinate those efforts with other Federal agencies for the purpose of delivering human services to target areas;
- To represent the Department on interdepartmental task forces concerned with rural development.

The Office is located within the Office of the Assistant Secretary for Human Development together with the Administration on Aging and other units serving special target populations. During FY 1974, the Office established a department-wide Rural Network which includes representation in each HEW Regional Office and major agency including the Administration on Aging. The Office works to build the capacity of this Network to provide information and referral services with respect to HEW programs available to support rural development.

Other activities of the Office which may have indirect benefits for the rural elderly include: (1) a study of selected rural human service projects from which describes principal barriers to service delivery, and summarizes characteristics of successful systems; (2) an analysis of HEW obligations to rural areas published by the Senate Subcommittee on Rural Development, Committee on Agriculture and Forestry; and (3) a contracted evaluation of the Concerted Services in Training and Education Program-a manpower and community development program devoted solely to rural areas.

II. SOCIAL SECURITY ADMINISTRATION

Programs Administered by the Social Security Administration

The Social Security Administration (SSA) administers programs which provide protection against loss of earned income due to retirement, disability or death for over 90 percent of the workers and their families in the United States. It also administers the Medicare programs, which provide hospital insurance and voluntary supplementary medical insurance protection for virtually all individuals in the United States who are age 65 or older, as well as for eligible disabled persons under age 65. Beginning January 1, 1974, the SSA also has been responsible for payments to aged, blind, and disabled persons under the Supplemental Security Income program which has replaced the State programs of aid to the aged, blind, and disabled formerly administered as grant programs by the Social and Rehabilitation Service.

Benefits to Older Persons

Under the retirement, survivors and disability insurance programs (title II of the Social Security Act) monthly cash benefits are paid to aged or aging persons, their dependents and their survivors. The following categories of older persons can receive monthly cash benefits:

- -- Insured workers between the ages of 62 and 72 who have substantially retired from gainful employment.
- -- Insured workers age 72 and over, without regard to work status.
- -- Insured workers up to 65 years of age who have worked a specified period of time in covered employment and have a medically determinable disability, which can be expected to last for a continuous period of 12 calendar months, and which prevents them from engaging in any substantial gainful activity.
- -- Certain individuals age 72 and over who are not insured under the regular social security program.
- -- Wives or dependent husbands age 62 or over of retired or disabled insured workers.
- -- Widows or dependent widowers of insured workers age 60 and over.
- -- Certain disabled individuals age 50 and over who qualify as widows, widowers, or divorced wives of insured workers.
- -- Dependent parents, age 62 or older.

Of the 31,700,000 beneficiaries receiving monthly retirement, survivors or disability insurance benefits at the end of September 1975, about 23,500,000 were age 62 or over. According to statistics updated to include January, 1975 approximately 92 percent of all persons age 65 and over either receive retirement, survivors or disability insurance benefits or are eligible for benefits on retirement. This proportion will grow until practically all aged persons are protected. The minimum monthly benefit for a retired worker who meets the regular insurance requirements is $101.40 under present law. For retired couples the present minimum is $152.10. This is subject to actuarial reduction if the benefit is taken prior to age 65. For those persons age 72 and older who qualify for uninsured (Prouty) benefits the payment to a single person is currently $69.60 a month and for a couple $104.40 a month. Average monthly benefits being paid at the end of December 1975 for retired workers was $207.00; for retired workers and their wives $344.00; for aged widows $194.00; and for disabled workers $226.00.

Title XVI of the Social Security Act as amended, now provides for a federally administered and financed Supplemental Security Income (SSI) program for persons aged 65 and over and for the blind and totally disabled. This program was effective January 1, 1974. It assures income of at least $157.70 per month for an individual and $236.60 per month for a couple. Under present law, in July 1976 the support levels are estimated to increase to $168.30 and $252.50 respectively. Certain income disregards included in the law allow some limited additional income, and encourage beneficiaries to work when they are able to do so. Lien laws are not applicable and, generally, beneficiaries may retain their homes and automobiles. Eligibility requirements and support levels are the same in all States. To assure that recipients of benefits under the former State administered programs for the aged, blind, and disabled suffer no loss of income under the Federal SSI program, States are required to supplement the Federal benefit. States may also supplement the Federal benefit payment to SSI recipients regardless of whether they are recipients "converted" from State assistance rolls to the Federal SSI program or newly eligible. States may administer their own supplementation payments or choose Federal administration. States which choose Federal administration have two advantages. First, the Federal Government pays all administrative costs of making the supplementation payments; and second, States are protected, generally, from paying more out of State funds than they paid in calendar year 1972. Estimated Federal benefit payments to the aged, blind and disabled under this program in fiscal 1976 will amount to $5.2 billion, of which $1.9 billion will be to persons age 65 and over.

On December 30, 1969, the President signed into law the Federal Coal Mine Health and Safety Act of 1969. The Act was amended on May 19, 1972. Benefit payments are made under this law from general revenues to coal miners who are totally disabled due to pneumoconiosis ("black lung disease") and to widows of coal miners who died due to pneumoconiosis. These benefits are increased if the beneficiary has eligible dependents. Benefits also are payable to orphans, and in certain circumstances to totally dependent surviving parents, brothers and sisters. Many of the beneficiaries are aged because the Act permits former coal miners and widows to qualify without limitations on either age or how long ago the disability occurred. In fiscal 1975, benefits paid to persons age 65 and over under this program were $608 million and in fiscal 1976 payments to such persons are expected to be $640 million and $626 million in fiscal 1977.

Health Insurance Benefits

In fiscal 1976, an average of 22,600,000 persons aged 65 and over and 2,300,000 disabled persons in the United States will be afforded basic Medicare protection. Under Medicare, hospital insurance beneficiaries are protected against the costs of inpatient hospital services, post-hospital skilled nursing facility services and home health services. In addition, the voluntary supplementary medical insurance program covers the cost of physicians and related services. Both parts of the Medicare program provide for payment of these costs subject to certain deductible and co-insurance amounts.

Payments to hospitals, extended care facilities and home health agencies for persons aged 65 and over under the hospital insurance program are expected to total an estimated $11.0 billion in fiscal 1976 and $13.5 billion in fiscal 1977. Supplementary medical insurance payments for aged persons in fiscal 1976 and fiscal 1977 are estimated to amount to $4.2 billion and $5.3 billion respectively.

Services to Aged Individuals and to Community Groups

The social security programs are administered through a network of district and branch offices. Local communities are served by 633 district offices, 665 branch offices, 3,442 resident stations and contact stations, and 28 teleservice centers. Every attempt is made to tailor services to individual needs and desires.

Thus, all offices provide face-to-face interviewing in the office or in the individual's home, telephone service, and mail service.

Social security district offices provide information to the public and answer inquiries about the benefits administered under titles II, XVI, and XVIII of the Social Security Act. They also receive, develop, and initially adjudicate claims for such benefits. Applicants are assisted in securing the factual information needed to determine eligibility for benefits and are advised of their rights. For adult beneficiaries who are not capable of managing their funds, a person other than the beneficiary is selected by SSA to receive the checks and is held accountable for using the benefits in the best interest of the beneficiary.

Social security offices traditionally have provided a referral service to community members, groups, and agencies. In many communities the social security office is the only point at which information and referral services are available.

In the areas of community and Government-wide planning, SSA plays a vital role. Data about the numbers of aged, disabled, survivors, and health insurance beneficiaries is invaluable in planning services to meet existing needs, as well as in long-range planning endeavors. At the national level, SSA's planning is coordinated with planning of other departments, agencies, and organizations, both public and private, such as the Department of Agriculture, Public Health Service, Administration on Aging, Social and Rehabilitation Service, Department of Housing and Urban Development, ACTION, American Public Welfare Association, National Council on the Aging, and the American Red Cross.

Similarly, regional offices engage in planning and coordination of SSA activities at the regional level as these relate to other public and private agencies and programs that serve the aged. The advent of Medicare also required extensive interface with numerous organizations and facilities which serve the aged. To facilitate effective administration of the Supplemental Security Income program, regional teams are providing important liaison between SSA and State departments of social service to assure that applicants and recipients of assistance payments are referred to both agencies as appropriate.

At the State level, SSA provides assistance to State health departments to fulfill Medicare requirements and to promote full potential for care of the aged in institutions, out-patient, and home care facilities. More recently, very extensive coordination with States was required for implementation of the Supplemental Security Income program.

At the local level, SSA participates in interagency community planning for development of resources with many health and welfare agencies. These include representatives of health and welfare councils, local government officials, local representatives of national public and voluntary agencies such as ACTION, U.S. Department of Labor, National Council on Aging, County Commissions on Aging and senior citizens groups, American Red Cross, etc. Projects resulting from this participation often involve substantial numbers of older people recruited to perform a variety of activities throughout the community as well as in SSA offices. Examples of these activities include outreach programs such as FIND, Medicare Alert, and SSI Alert, in which older volunteers contact vast numbers of potential aged individuals to assure that all who are eligible take advantage of income, health, and welfare programs available to them. Social security offices cooperate with all such projects and provide training to volunteers on eligibility requirements, procedures, etc. While some aged workers are volunteers, others are paid nominal amounts by ACTION under the RSVP and Foster Grandparents programs or by the Department of Labor under contract with local groups serving the aged. Most older people working in social security offices are paid, and work part-time, performing clerical, and sometimes higher level functions. Projects and activities such as those described, sponsored by the government and by private agencies, have clearly demonstrated the effectiveness of older worker performance as well as advantages to the retiree and to the employing agency.

Research on Economic Security for the Aged

The Social Security Administration research and statistical program provides information derived from the operations of the Social Security Administration system, from population surveys and from studies of related public and private income maintenance programs that is useful for continuous evaluation of the effectiveness of the social security program in providing economic security for the aged, including protection against the costs of hospital and medical care. Data are developed and published regularly in the Social Security Bulletin and its Annual Statistical Supplement, in special published reports and in various other ways to meet user requests.

Indicative of the types of information made available and of interest to officials and groups planning programs for the aged are: continuously reported data on claims and benefit payments to retired workers and their dependents; the findings of surveys of the aged population, which provide information about the level of economic security that social security benefits support (information obtained on income includes sources of income of individuals and families, level and types of assets owned, special demands on income such as medical expenditures, etc.); special studies that show the changing share of the total national output going to the aged, what measures of income adequacy are most appropriate and meaningful, the relationship between individual and family income over the life cycle; continuing statistical series that are concerned with the totality of public and private income maintenance protections and the relative weight of the social security program in that totality; and research to measure the impact on the aged of both public and private health and medical care programs, to identify and define gaps and unmet needs under the health insurance program, and to examine and evaluate the economic consequences of the health insurance program. Social Security Administration research draws heavily upon basic data in the social security system, data from the population survey program, and upon data from the Bureau of the Census, Bureau of Labor Statistics, and other statistical sources.

III. PUBLIC HEALTH SERVICE

A. HEALTH SERVICES ADMINISTRATION

1. BUREAU OF MEDICAL SERVICES

The Bureau of Medical Services comprises five (5) Divisions, one of which, the Division of Hospitals and Clinics, sponsors programs relating directly and indirectly to the aged.

The Division of Hospitals and Clinics holds primary responsibility for providing health care to specific groups of Federal beneficiaries. Health care is provided on a reimbursable basis to other beneficiaries and community residents when resources are available within the system. In addition to the provision of direct health care, the mission of the Division of Hospitals and Clinics includes health education and training, medical research and community health service programs.

During fiscal year 1975, of a total of 30,720 discharges from hospitals of the Division of Hospitals and Clinics, 4,151 were age 65 or over. The average length of stay for elderly men was 23.1 days and for elderly women 21.7 days, compared with an average length of stay of 16.9 days for all patients. Consistent with this finding is the fact that older patients are affected to a greater extent by chronic conditions which require longer periods of hospitalization, and for similar conditions, older patients tend to receive longer periods of hospital care than younger patients.

A high proportion of elderly persons receiving in-patient services are American seamen, who constitute the major beneficiary group cared for in PHS hospitals. The problems presented by this group of patients are similar to those presented by aging patients in general with one exception: there are probably more single males in this group than in the general population. Because of this, finding suitable nursing homes for their long-term care constitutes one of the real problems in meeting the needs of aging patients served by the Division of Hospitals and Clinics.

In October 1975, a Day Treatment Center for the Elderly was opened at the USPHS Hospital in Baltimore, Maryland. This program provides an alternative to institutionalization for elderly patients by providing supervision and personal care services to older persons with physical, mental or social impairment. The capacity of families to continue helping to maintain elderly relatives at home is depleted when no relief is available and institutional placement is often made not because the older person needs institutional care but because the right kinds of assistance needed do not exist. The Day Treatment Center should solve some of the difficulties of daily living, provide respite to families with elderly relatives, and enable the older person to return at night to the home setting. The aged indicate a strong preference for remaining in their homes and the Day Treatment Center would greatly assist both the family and the elderly in this regard.

The Day Treatment Center for the Elderly provides an organized program of activities and health services during the day in a protective group setting for purposes of personal care which is designed to activate, motivate and retrain the elderly to sustain or regain maximum functional independence. Individuals participating in the Center are aged persons referred from PHS beneficiary groups, the Geriatric Evaluation Service of the Baltimore City Health Department, community organizations and private physicians.

Approximately 20 medical research projects indirectly related to aging were ongoing within the nine hospital facilities of the Division of Hospitals and Clinics during fiscal year 1975. These include studies of natural history of disease, descriptive physiology and pathophysiology, and therapeutic trials. Studies on various aspects of cardiovascular disease comprise the major component of the clinical research related to aging.

During fiscal year 1976, in addition to beginning patient care in the Division's first center for geriatric day treatment in Baltimore, plans are underway to explore feasibility of developing similar additional centers for geriatric day care within this system of health care facilities. As these facilities gain experience with day treatment centers, they will develop the capacity to undertake studies of the relative merits of innovative concepts of geriatric health care delivery. The Division presently envisions studies of different intermittent patient scheduling plans including night treatment centers, and studies on the provision of day treatment to various selected patient subgroups including those requiring a major commitment of conventional medical care, as opposed to the emphasis on rehabilitiation services as usually provided by day treatment centers in the U.S. Potentially, the multiple facilities of the Division of Hospitals and Clinics could be used to study many innovative elements within the spectrum of geriatric health care delivery as part of a centrally coordinated program within DHEW.

Programs of the Division of Emergency Medical Services, which provides national leadership in the development and expansion of comprehensive area emergency medical systems, are directed toward interests of the aged as part of the general population. Additionally, this Division presently sponsors a project specifically targeted toward the aged entitled "Effects of an Emergency Alarm System for the Aged."

Health delivery systems within the purview of the Division of Health Maintenance Organizations provide services to the aged as part of the general population. The Division of Coast Guard Medical Services and the Division of Federal Employee Health have no programs targeted for the aged.

2. BUREAU OF QUALITY ASSURANCE

a. Medical Care Standards

When Medicare was enacted in 1965, the Secretary of HEW was required to establish national conditions of participation for a variety of providers of services to protect the health and safety of program beneficiaries. Prior to Medicare, little existed in the way of established professionally acceptable standards for some providers of services, particularly for long-term care facilities, home health agencies, and independent laboratories. Qualifications required for many types of health care manpower also were inadequate to ensure a safe level of quality of services. The Division of Provider Standards and Certification of the Bureau of Quality Assurance, working with the Social Security Administration, was assigned principal responsibility for standard-setting and surveillance of the program, and for other professional health aspects of Medicare of direct benefit to program beneficiaries.

The objective of the Division of Provider Standards and Certification is the improvement of the health status of Medicare and Medicaid beneficiaries by ensuring that the types, quality, and quantity of services provided under the program are appropriate to patient needs. Since the beginning of the program, the effects of the standards, along with their continuous evaluation and revision, have been to promote the upgrading of individual institutions and agencies, to improve State licensure and certification programs, and to stimulate changes in national (non-governmental) accreditation programs. In establishing standards and surveillance techniques for individual health care practitioners, problems of qualifications and availability have proved difficult. However, Medicare has helped to focus attention on problems of health manpower--from physicians to nurse aides--including their supply and the surveillance of the services they provide A variety of techniques for assuring quality of services under Medicare, Medicaid, without unduly limiting the supply of health care personnel, including the utilization of proficiency examinations for designated categories of such personnel (e.g., physicial therapists, practical nurses licensed by waiver, clinical laboratory technologists, cytotechnologists, psychiatric technicians) have been employed and are continually evaluated by the Division of Provider Standards and Certification.

The Conditions of Participation for Skilled Nursing Facilities and Intermediate Care Facilities, and interpretive guidelines for use by State agencies and providers, and Conditions for Coverage of Services of Independent Laboratories were revised and issued in 1974. The revised regulations for skilled nursing facilities include special provisions for upgrading the quality of medical direction in these facilities, for improving discharge planning, and for safeguarding and ensuring patients' rights. Similar efforts were made to revise and update, in 1975, the Conditions of Participation for Hospitals. Experimentation and developmental activities are currently underway in the area of standards to ensure the quality of services provided in ambulatory health care centers. The Division has also directed attention to the problems of fire safety in long-term facilities and, under contract with the American Nursing Home Association, is conducting a study ("Nursing Home Burn-out Study," involving onsite burn-out testing) that should lead to the identification of needed modifications to the Life Safety Code of the National Fire Protection Association. As the Department's operational focal point for the interagency coordination of such efforts, the Division has worked in close collaboration with other health agencies in the Department, with the Bureau of Health Insurance, SSA, and with the Medical Services Administration, SRS. Training and enforcement activities related to these efforts have continued, and new initiatives have been made along several fronts in the area of training, with Division headquarters and regional office personnel closely collaborating with headquarters and regional office staff of BHI and MSA.

The Division has participated in several ongoing programs designed to promote and maintain the quality of care provided to elderly persons. For example, the Division has provided support to the Bureau of Health Insurance and Medical Services Administration regional office staff in the conduct of comprehensive program reviews of State Medicare agencies; these reviews are a means of assessing the effectiveness of program policy and guidelines and the manner in which these are administered in the States. Through the provision of consultative and technical assistance, and other support activities, the Division has been involved in and has continued to promote quality assurance mechanisms.

Another ongoing comprehensive program instituted in 1970 was to improve the interpretation and uniform application of Federal health care programs by State agency personnel through training and evaluation of individual surveyor performance. This program was developed to meet a specific need following the enactment of Medicare and Medicaid, and has been supported by the States, the Social Security Administration, and the Social and Rehabilitation Service, all of which have assisted in its development. The health facility surveyors have a major responsibility for ensuring that long-term care facilities, hospitals, and home health agencies, and other providers and suppliers of service, provide safe and adequate care and comply with required standards in serving Medicare and Medicaid beneficiaries.

Still another way in which the Division has a relationship to the health services for the aged is by recommending changes in Medicare policies and legislation, and in conducting studies. Some of these recommendations and studies have directly affected the accessibility, quantity, and quality of care in the Medicare program.

b. Professional Standards Review Organization

The Professional Standards Review Organization Program was authorized by the 1972 amendments to the Social Security Act. This provision requires the Secretary to establish and support a nationwide network of voluntary, non-profit groups of local physicians to regulate the quality of health care services paid for under Medicare, Medicaid, and Maternal and Child Health Programs. The purpose of the statute is to improve the quality of health care services and to make more cost effective the expenditures for health care services financed by Titles XVIII, XIX, and V of the Social Security Act. PSROs are to accomplish these purposes by applying sophisticated concepts of peer review through a system of voluntary local organizations, State Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

PSROs will review the medical necessity of services, the quality of care delivered, and the appropriateness of the care in terms of the level, duration, and methods of treatment. In reviewing medical necessity and quality, PSROs will be determining whether health care services provided are necessary on the basis of professionally developed standards of norms of care, diagnosis, and treatment. In reviewing appropriateness, PSROs must determine whether the level at which health care services are provided (e.g., inpatient, outpatient, intermediate care) is the most efficient as well as the most effective level. This peer review system will assure that payment is made from Federal and State funds for only medically necessary, appropriate, and quality care.

Initially, PSROs will place emphasis on the review of institutional services, especially those provided in the acute general hospital. Eventually, the scope of their review will be expanded to encompass all facets of the health delivery system.

The PSRO program relates closely to and must be integrated with other health care review activities required by the Social Security Act particularly as the Act was amended in 1972. The PSRO legislation intends that utilization review, and other duplicative review activities will eventually be eliminated and PSROs will assume responsibility for such activities.

In 1974 the country was divided into 203 PSRO areas designated by the Secretary of DHEW. By the end of FY 1976 it is expected that there will be 65 conditional PSROs.

The 63 conditional PSROs funded in prior years and the two funded early in FY 1976 began operation of their review systems in short-term general hospitals. The hospital peer review system that these PSROs are using is an integrated one, which includes concurrent review, medical care evaluation studies and profile analysis.

PSRO activities during 1977 will focus on the following major objectives: continuation of the conditional PSROs; converting an additional 55 to conditional status, and funding up to 10 Statewide Councils; funding 83 new planning PSROs in order to cover all 203 PSRO areas; implementation of all regulations issued during 1976; and coordination of the End-Stage Renal Disease (ESRD) and PSRO programs. About 120 conditional PSROs will be in existence by the end of 1977, and some of these will initiate review in long-term care facilities.

Another important objective relates to the evaluation of the impact of the PSRO program on the quality and utilization of health care services financed under Medicare, Medicaid, and Maternal and Child Health programs.

B. NATIONAL INSTITUTES OF HEALTH

On May 31, 1974, the Research on Aging Act (P.L. 93-296) was signed into law authorizing establishment of the new National Institute on Aging (NIA). On July 1, 1975, NIA was separated from its parent Institute, the National Institute of Child Health and Human Development. By January 1976 the NIA was functioning as a viable and independent organizational entity carrying out its mandate to conduct and support comprehensive, systematic, and intensive studies of the biomedical and behavioral aspects of aging and the related training of necessary personnel.

Aging is a natural phenomenon which, as far as is known, affects all higher forms of life and perhaps all living things. No matter how aging is defined, its implications for the individual and for society are profound. Twenty-two million Americans, 10 percent of our population, are now over 65 years old. In fifty more years, 40 million persons may be that old. Two-thirds of the Federal money spent on health in this country goes for persons over 65. One million people over 65 years of age live in institutions, and a significant proportion of them are incapacitated by a variety of diseases and degenerative conditions. Although the dimensions of the problem of aging are great, they can at least be diminished through continued research.

The obvious need for tangible and immediate improvement in the quality of life for the aged has shifted research away from its exclusive disease orientation with its study of the sick and institutionalized to a broader inquiry into normal physiological changes occuring with age, the behavioral constitution of the aged, and the social, cultural, and economic environment in which the elderly live.

By no longer defining aging as a disease process, but simply as the organism's progressive loss of ability, after maturity, to function optimally within its environment, NIA's research extends into many special fields of inquiry - cellular biochemistry, molecular biology, enzymology, behavioral sciences, sociology, and others.

Microbiologists, zoologists, physicians, and others approach the study of aging from different standpoints and for different reasons. An investigator working in one laboratory may be interested in aging at the molecular level because this may lead, one day, to ways of mitigating or preventing some disability of age. Sociologists working on problems of the relationships between health and social stresses--such as relocation and loss of friends and spouse--feel that their study will furnish a basis for helping aged persons better adjust to new circumstances.

In addition to supporting research in universities, medical schools, and other research institutions through the award of research grants, NIA also has staff scientists who conduct research at the Gerontology Research Center (GRC) in Baltimore, Maryland. GRC is a federally-owned facility on the grounds of Baltimore City Hospital. In addition to its own programs, the Center houses a number of non-government guest scientists conducting studies related to aging.

1. MENTAL CHANGE WITH AGE

One of the most disturbing aspects of aging is a condition related to the mental deterioration of the elderly called "senility." Although generally known by this single name, the condition is probably a mixture of disease-derived changes coupled with less specific and poorly understood deteriorative changes which are associated with growing old.

Many people's ability to remember words or numbers declines with age. This can be embarrassing for the person to whom it happens and frequently worries friends and family about his mental condition.

Recently, NIA scientists Drs. David Arenberg and Elizabeth Robertson-Tchabo found that a classical technique used to improve memory (mnemonics) can be taught to elderly people. Once learned, this technique can be used in a variety of ways to improve a person's recall. This procedure involves having the subject plan an imaginary trip to a series of well-known places, for example, different rooms in a home. Then he associates each of the items to be learned with stopping places on his imagined journey.

This simple method proved to be easily learned by older subjects and was quite effective in helping them store and recall information.

In order to study some of the deteriorative changes that do occur, researchers are conducting experiments in animals whose lifespans are short enough to observe the behavicral changes that occur with time.

One such study conducted by NIA-funded scientists shows that in rats there is a progressive loss of the ability to remember newly acquired information. This loss occurs throughout the entire adult lifespan.

Dr. James L. McGaugh at the University of California at Irvine has found a striking decrease in the power of memory in rats from early adulthood to the middle stage of life, and an additional decrease from that point to the period when rats are entering old age. These results have been found in two quite different kinds of memory tests. Although increased forgetfulness with advancing age has long been regarded as occurring in some elderly people, the evidence for it heretofore has been based on casual observation or on controversial evidence, with some regarding it as a consequence of disease or extreme old age. McGaugh's observations on healthy animals of various ages makes a strong case that increasing forgetfulness is a regular occurrence throughout adult life in normal and healthy mammals. More important, McGaugh's basic neurochemical findings strongly suggest the precise nature and location of brain activities which decline and that this decline is proportional to the decline in memory capacities. If McGaugh's findings hold up for mammals higher than rats, and if the memory-neurochemical correlations are not just an unusual coincidence, it is possible that experiments in improving memory by biochemical therapy could be conducted within a few years.

Another study of the aging rat brain conducted by Dr. Martin Feldman, an NIA grantee at Boston University School of Medicine, has shown that there is a striking anatomical change with age in rat brains. This change consists of a considerable reduction in the number of connections (synaptic connections) between the nerve cells that form important portions of the brain in higher animals (portions of the cortex).

According to other of Dr. Feldman's observations, impairment of learning in rats seems similar to changes that occur in humans. Anatomical studies like those reported by Dr. Feldman would be very difficult to conduct in humans because human brain tissue can ordinarily be obtained only from patients who have died of some disease. The damage from the disease condition then might not be distinguishable from what might be the "normal aging process."

Both Dr. Feldman's and McGaugh's findings suggest the suitability of the rat as an experimental animal from which something can be learned about human senility. If continued studies of rat and human brain substantiate the validity of this conclusion, we will at last have a good counterpart of human senility for experimental study.

Another NIA grantee, Dr. Merrill F. Elias of Syracuse University, is approaching the problem of mental change in the elderly from still another point of view. Dr. Elias has been investigating the effect of sustained high blood pressure on a person's ability to respond and make decisions quickly. The study, performed in collaboration with colleagues at the Veterans Administration Hospital, Syracuse, was done with young (18-31), middle aged (32-45), and older adults (46-59) to see the effects of aging. The test was designed to measure verbal and non-verbal thought processes. In some cases, participants were required to make complex decisions selecting answers from as many as eight alternatives.

The results showed that the speed with which participants responded declined with age. The patients with high blood pressure performed even more poorly than healthy subjects, although not all the patients with elevated blood pressures reacted more slowly than control subjects of the same age. Those whose blood pressure had been previously controlled by medication showed greater slowing of their ability. The type of hypertensive disorder each patient had seemed to dictate whether medication improved or weakened performance. Further studies will be undertaken to pin this down more specifically.

Alcohol and Behavior

Last year at GRC Dr. Robert Vestal and co-workers reported on the ability of young and old men to metabolize alcohol introduced directly into the bloodstream. They found that older men handled alcohol, physiologically, as well as the young

Related research by Dr. Robertson-Tchabo and colleagues, however, showed that alcohol has a more severe behavioral effect on elderly men than it does on younger men. All subjects studied were healthy, male volunteers from the Baltimore Longitudinal Study, an ongoing study of some 600 men to observe individual changes which occur over an extended period.

The study showed that when blood alcohol levels are relatively high (above the legal level for intoxication) the older men manifest greater declines on tests of memory and decision-making. This was true even though the older men appeared less intoxicated, with fewer reporting they felt impaired or "high".

It appears that older men under the influence of alcohol are at greater risk to make mental errors than are younger subjects since they have larger performance impairments coupled with a decrease of awareness of these deficits.

2. SELF CONTROL OF BLOOD PRESSURE

An estimated 19 million Americans 45 years of age or older are victims of hypertension, more commonly known as high blood pressure. The magnitude of this problem in middle-aged and older adults makes it imperative that more be learned about high blood pressure and the most effective ways to treat it.

At GRC, Dr. Bernard T. Engel and co-workers have succeeded in teaching patients with high blood pressure to control their own blood pressures using a technique known as operant conditioning. This technique selectively encourages behavior by rewarding the correct response.

Five patients referred to the NIA by the Baltimore City Hospital's hypertension clinic learned to increase or decrease their blood pressures while at the laboratory. The patients, men and women, ranged in age from 46 to 70 years of age.

The laboratory training taught the subjects to raise and lower systolic blood pressure (the higher pressure on a blood pressure reading). A display of lights, much like traffic signals, was used to help the patients learn. For example, when the red light was on this meant they should lower their systolic blood pressure; green meant they should raise the pressure; and, yellow indicated the correct response was being given. This yellow light served as a patient's "feedback" showing that the correct response had been made and thus rewarding successful behavior. Another reward or reinforcement was a meter, visible to the subject, which gave the patient an accumulated numerical score of performance with each successful response advancing the meter two points.

When laboratory training ended, the patients continued training in their own homes. All the patients were able to exercise self control of their blood pressure during a three month follow-up period. The subjects' success in controlling their own blood pressures during follow-up showed that laboratory skills, properly taught, can also be used effectively by patients in their own homes.

3. THE BIOLOGY OF AGING

The Aging Immune System

The ability of the body to protect itself against disease (immune function) decreases with age at the same time that various protective systems begin to malfunction. The observation, made some 45 years ago, that the concentration of natural antibodies, the most important defenses against foreign invaders such as germs, declines with age is probably the earliest scientific evidence we have of this system. Discoveries in recent years have pointed up the importance of this loss, at the same time that the possibility has arisen that this can be improved by medical treatment.

This year, NIA scientists in the Laboratory of Cellular and Comparative Physiology, GRC, found what they believe to be one reason for the loss of normal immunity that occurs in older people. Research showed that older animals have a definite increase in a population of cells known to interfere with the disease fighting activities of the body's immune cells.

Previous studies have shown that one possible way to bolster immunity in the older animal is to combine transplants of thymic and bone marrow tissues from young animals. In some strains of old mice this restimulates the immune system. It has now been shown that injections of a sulfur drug (Mercaptoethanol) also restore immune function in aged mice.

At the University of California, Los Angeles, NIA grantee Dr. Roy L. Walford has found that by restricting the number of calories or the protein content of the diet of laboratory mice he was able to prolong their lifespan 15-40%, to lower the incidence and growth of spontaneous and transplanted tumors, and to increase resistance to some viral infections.

Using immunologic measuring devices the mice were first tested at 3-4 months. The immune responses of the restricted mice were less than those of the controls; but by one year of age, this was reversed. The regulated animals possessed an immune system which remained or acted younger longer than the immune systems of animals on a nonrestricted diet. Dr. Walford is also examining various protein dietary combinations to study their effects. Severe restriction of protein, he found, did have an undesirable effect.

One important problem in biology concerns the way by which scavenger cells (macrophages) recognize and remove deteriorated cells from the body. NIA investigators use human red blood cells to study this problem since the macrophages routinely ingest and destroy red blood cells at the end of their 120-day useful life span in the circulation.

Some recent studies conducted by Dr. Marguerite Kay at GRC indicate that macrophages tell the difference between young and old red blood cells by recognizing an accumulation of immunoglobulin G on the surface of the old red blood cells. Immunoglobulin G is a protein in human blood involved in immune responses. Young cells show only trace amounts of immunoglobulin G, while old cells have definite accumulations on their surface.

These findings point to existence of a gradual build up of immunoglobulin G as red blood cells age in the circulation. Once a critical level is reached, the scavenger cells ingest and destroy these cells.

Protein Production Errors

One fairly popular theory of aging states that the cellular machinery needed to produce proteins necessary for cell function becomes error-prone in old cells.

This theory was tested and proved invalid by Dr. Josef Pitha and his co-workers using human cells in tissue culture. The cells were infected with polio virus. Usually this virus produces a large protein molecule which is then broken down by cellular enzymes into smaller protein units. If the large polio protein synthesized in old cells contained errors then it would not be recognized by the cell's enzymes. Thus the large protein would not be broken down and more of it would be found in old than in young cells.

NIA scientists discovered that the protein is degraded in both "old" cells (those that have gone through 50 cell divisions) and "young" (20 cell divisions) cells; thus, proving that the protein production error theory of aging is not valid.

Heart Function in the Aged

Previous studies in the Clinical Physiology Branch, GRC, have shown that age is associated with a defect in the relaxation phase of the rhythmic contractions in isolated rat heart muscle. This research has now been extended to studies in men taking part in the Baltimore Longitudinal Study. Studies using a non-invasive technique (echocardiography) to measure heart muscle function show that the defect in muscle relaxation also occurs in man.

Meanwhile, studies in the rat have continued. Earlier work suggested that a defect in calcium transport underlies the muscle relaxation difficulties of aging. Since digitalis, a drug commonly used to treat heart disease, inhibits calcium transport in heart muscle, its effect on aging heart muscle from old and young rats was tested. Indeed, the toxic effects of digitalis occurred earlier, that is at lower doses, in the old heart muscle than in the young. In this sense, then, there is an increased sensitivity to digitalis in the elderly.

The increased stiffness noted in the aging hearts of both man and rat suggest that further studies into the mechanisms responsible for these changes could provide information useful in treating heart disease in older people.

In related work at GRC's Laboratory of Molecular Aging the movement of calcium within cells was investigated. Calcium is required for the contraction-relaxation cycle that occurs during each heart beat. Relaxation takes place when calcium is stored in a separate compartment within the muscle cells. Contraction occurs when this calcium is released. Biochemical studies of this compartment's ability to store calcium reveal a decrease in this ability for older animals. Thus, the longer time taken to relax old heart muscle may be linked to the lowered ability of this compartment to actively transport the calcium needed to trigger heart contractions.

4. HORMONES AND AGING

The body's ability to respond to stress, illness, and the like is dependent to a great extent on the actions of hormones. With increasing age, the body's ability to respond to these hormones generally diminishes.

It is important for scientists to learn more about the ways in which aging causes these changes. All hormones act initially by combining in a lock and key arrangement with certain sites or receptors on surfaces of the cells or within the cells themselves.

Recent studies by scientists at GRC have shown that for those hormones that act on the surface of the cells, the age-related loss of responses varies for different hormones as well as for different tissues. For example, in fatty tissue cells the response diminished progressively. The losses in this tissue occur first in its response to the hormone glucagon; then to another surface hormone, ACTH, and still later to epinephrine.

Liver, on the other hand, shows an entirely different aging pattern. Liver tissue response to the hormone epinephrine actually increases with age. For other hormones, acting within cells, an age-related loss of the specific hormone receptor molecules has been identified for neurons and fat cells. These findings provide important leads to a possible explanation for the differences in hormonal response that often accompany aging.

5. FOOD APPEAL

Most elderly people have a severely diminished sense of taste and smell leading to loss of appetite and ultimately to poor nutrition. The sense of smell is often the first of the senses to decline with age. As a result, older people tend to identify food mainly on the basis of its texture. Because their sense of taste is lessened, the elderly tend to pour large quantities of salt on their food. This additional salt then aggravates existing heart and blood pressure problems.

In order to deal with the problem of declining sense of taste and smell with age, an NIA grantee Dr. Susan Schiffman at Duke University is experimenting with ways to fortify taste and smell in food with special flavor and aroma additives. Much of the experimentation is with protein-rich, inexpensive foods like new-textured soybean products.

6. DEVELOPMENT OF A SUITABLE ANIMAL MODEL FOR AGING RESEARCH

One of the major obstacles to the study of the aging process has been the absence of a suitable laboratory animal on which scientists could either perform their experiments or systematically observe the aging process. The problem was further complicated by the fact that many animals which are similar to humans have, like humans, life cycles which are too long for routine laboratory studies.

Until recently, investigators in laboratories throughout the country were unable to get even the most commonly used laboratory rats and mice in the full spectrum of the aging process within a single species. Few, if any, aged animals were being maintained in a germ-free state. The few animals that survived to "aged" were usually so fragile that their use as models of aging, uncompromised by disease, was questionable. Furthermore, if the animals did survive to "aged", the trauma of the transfer from one laboratory to another was frequently fatal.

The establishment of a germ-free colony of laboratory rats and mice up to two years of age and older, whose genealogy is known, is a major contribution by NIA and its commercial contractor to the advancement of basic studies of the aging process. Although the animals are still available only on a limited scale, they have been shipped to investigators from coast to coast. The project has provided a basis for the development and expansion of needed strains and species of animals for aging research.

C. ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

NATIONAL INSTITUTE OF MENTAL HEALTH

There are signs of increased concern about our older citizens particularly as evidenced by legislation expressing a national commitment to be more responsive to their needs. Progress has been made in a broad range of areas intended to ensure a better quality of life for the old and enable them to better live in security with dignity and self respect, without discrimination and exclusion, and able to exercise freedom of choice.

The older mentally impaired are particularly vulnerable to inequities in benefits and services. Services do not always match their needs. The care that is provided them is often inappropriate. Community supportive services are not always available to them to obviate unnecessary mental hospital or nursing home care.

The NIMH, in keeping with its national leadership mandate to better serve senior citizens, has worked to improve their mental health through augmenting and bettering ways of delivering mental health services. NIMH has also supported education and training of appropriate manpower, and has funded research in factors associated with mental health and mental disorders in later life, to learn more about preventing mental impairment and how to maintain psychosocial functioning of older persons. Emphasis is placed on collaborating with other agencies and programs and with consumer groups.

To sharpen its research focus on the elderly, NIMH adopted the following guidelines:

1. A continuation of the biological and psychosocial research efforts in order to better isolate the causes of mental disorders affecting the old so as to increase our ability to prevent their occurrence and to develop more effective care;

2. Utilizing four major considerations to guide the professional judgement of planning, program, and management staff in arriving at research priorities. These priority setting factors were listed as:

   a. Relevance - meaning the degree of the relationship of the problem area to the mental health of our citizens.

   b. State of the Art - an assessment of what is feasible.

   c. Neglect of Area - an assessment of the work being done on the problem by other agencies.

   d. Social Importance - including incidence, prevalence, and extent of loss (such as decreased productivity, or pain caused by the problem).

NIMH priorities in Aging are classified in three major categories of etiology, diagnosis, and treatment of mental disorders; development and delivery of mental health services; and prevention of mental illness.

To design and implement effective methods of treatment requires a considerable research effort on the part of NIMH to produce further understanding of the nature of the psychiatric diseases which affect older people and to test out and evaluate the effect of various treatment approaches. One of the most valuable contributions NIMH has to make to the aging is to provide a means by which research findings, no matter what their origin, can be translated into practical programs affecting the mental health of the elderly. It is this opportunity for research utilization that is unique to NIMH since it bears responsibility for services and training as well as for research.

The newly established NIMH Center for Studies of the Mental Health of the Aging made as its first order of business a convocation of the leading authorities in the field to discuss research priorities as they relate to mental health and mental illness of the old. General concerns for the Conference were on research gaps, research areas and needs methodology, assessment and application of research to training and services. The planning committee for that conference identified the critical areas for discussion as epidemiology, successful adaption, crises, organic brain and mental illness, and psychopharmacology. Recommendations from that meeting should help the Institute shape its program.

Establishment of the Center was another step in implementing the recognition of aging as a priority of the Institute. Drawing on existing resources, it has assembled a small staff to intensify activity to better serve the old. Following the successful research conference, additional meetings are planned to consider service and training priorities. The timing of the new Center coincides with legislation authorizing a Secretary's Committee on mental health and mental illness of the elderly and with the new provisions of the Community Mental Health Centers Act (Public Law 94-63), mandating specialized mental health services for the elderly.

The Secretary's Committee calls for a study to make recommendations respecting the future needs for mental health facilities, manpower, research, and training to meet the mental health care needs of elderly persons; the appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions; and proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health care of the elderly. It is expected that the Institute will be involved in its activities.

The greater emphasis in recent legislation on deinstitutionalization remind us that the bulk of the institutionalized are the mentally impaired and that most of those in institutions are elderly. Of necessity, the mental health system plays a major role in this process and calls for resources commensurate with the responsibility.

D. HEALTH RESOURCES ADMINISTRATION

1. NATIONAL CENTER FOR HEALTH STATISTICS

All health statistics prepared by the National Center for Health Statistics (NCHS) can be presented in terms of specific age groups.

Measures of morbidity among the noninstitutional population include the incidence of acute conditions and injuries, number of days of disability, prevalence of chronic conditions, and the number of persons whose activities are limited due to chronic conditions. The latter category is the measure of health status which increases most rapidly among the elderly.

These data from the household Health Interview Survey are usually presented for the broad age groups 45-64 and 65 and older so that some other characteristics which are related to both age and health can also be shown: family income, educational attainment, and living arrangements. Also reported in the interview survey are number of visits to physicians, medical specialists and dentists, episodes of hospitalization, days of hospitalization, expenditures for various types of health services, and sources of payment.

The Health Examination Survey of smaller national samples of the noninstitutionalized population yields high quality diagnostic data on some of the chronic diseases most prevalent among older people--specific types of heart disease, hypertension, arthritis, visual and hearing defects, and dental conditions. It also provides data on several physiological characteristics (serum cholesterol level, blood glucose level, blood pressure, and body measurements to identify obesity) and on symptoms of psychological distress. In addition, current examinations include assessment of nutritional status and data on the prevalence of other chronic diseases such as diabetes and kidney disease. In this Health and Nutrition Examination Survey, the aging have been over-sampled to insure reliable statistics.

Separate surveys are made of the residents and patients in both long- and short-term care institutions--chronic disease hospitals, nursing homes, and general hospitals. These surveys provide data, classified by age and other characteristics, on utilization, diagnosis, medical and nursing care received and costs. "Charges for Care in Nursing Homes" (1972), a report from a recent Nursing Home Survey, includes data on coverage by Medicare and other types of medical assistance payments. Also published in 1972 and from the same survey were reports on "Employees in Nursing Homes" and "Services and Activities Offered to Nursing Home Residents."

The National Center for Health Statistics completed data collection and processing for the first national survey of 2000 nursing homes in December 1974. This survey provides data on the operating costs of the homes and on the characteristics of employees on their staffs, including staff attitudes as an indication of quality of care. In addition, data was collected on approximately 20,000 resident patients in these homes. These data include sociodemographic characteristics, mental status, health status, assistance needed in performing activities for daily living, diagnoses, medical history and last examination, charges and source of payment, and any discharge plans. Data from this survey is currently being analyzed and published. The second National Nursing Home Survey is underway and includes data on discharged residents, changes in facility characteristics, and residents' health status.

The National Center for Health Statistics also produces the national and State life tables and data on causes of death by demographic characteristics and geographic distributions of the population.

2. NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

The Division of Long-Term Care, National Center for Health Services Research, was delegated prime responsibility for long-term care and aging, with the dual functions of research and development in long-term care and aging, and provider improvement activities designed to improve the quality of care in long-term care institutions by upgrading the performance of long-term care personnel through short-term training programs. Although the Division is administratively located in NCHSR, the National Center no longer has legislative authority for short-term training; therefore, provider training activities have been funded by the Bureau of Health Manpower.

In the following description of research of relevance to the aged being conducted by the National Center for Health Services Research, it should be noted that in addition to the research specifically for the elderly, and the long-term care research that has a strong focus on the elderly, there is also included reference to broader research inquiries that span acute and long-term care interests. Findings from such studies can be utilized to improve the quality of care received by the elderly and lead to a more effective health delivery system to benefit the elderly along with the rest of the population.

Through grants and contracts, research relating to the aged is being conducted in several broad areas: (1) quality of care; (2) management information and data systems; (3) alternatives in long-term care; and (4) systems design, development and analysis.

(1) Quality of Care

The Patient Classification for Long-Term Care--User's Manual developed through a grant is widely used as a basic tool for patient assessment. Comprised of a set of descriptors that form a uniform terminology to assess individual status, the information helps the decision maker in care-planning, placement, appropriateness of care, staffing, reimbursement, utilization and medical review. These descriptors are being utilized in a grant to assess the status of nursing home residents at several intervals in time.

A related award was directed at modifying and testing the Collaborative Patient Assessment Instrument to determine patient profiles, assess patient care needs, and develop the protocol for producing care plans. Appropriate care plans are being developed and compared with observed patterns of service rendered to develop guidelines for review of the appropriateness and extent of services provided. Refined guidelines will be implemented in selected sites to test regional generality and applicability for PSRO.

Another grant is designed to carry out the planning and development activities necessary to research the variables related to the outcomes of nursing home care (length of institutional stay, mortality rate, place to which discharged, change in functional status, change in mental status and consumer satisfaction). Staffing patterns, cost, employee and administrator attitudes, environmental and structural variables and ownership-control status, among other variables, will be considered for relationship to the outcome measures. The acceptability of the research protocol and design to nursing home administrators is assured through a close coordinating effort. The instruments and quality construct for a quality evaluation system were developed through a contract, designed to be an effective tool for use in the regulatory mode by surveyors to ascertain the quality of care provided by a given institution based on the needs of its patient population. For testing in a regulatory mode, the quality evaluation system was incorporated into the Long-Term Care Automated system of the Illinois Department of Public Health and will be utilized in 100 long-term care facilities by the State surveyors. Should this quality module be effective, it will then be available for use in other State automated systems.

A study is being directed toward the development of an outcome measure of health care: The Sickness Impact Profile (SIP). The SIP is a scaled measure of sickness-related dysfunctions.

A "health accounting" strategy to permit physicians to establish their own outcome standards is being developed and will be evaluated.

Support is being provided for analysis of data on lung cancer patients to identify factors associated with differential survival, and to develop principles for construction of clinical indices to hopefully lead to improved lung cancer treatment.

(2) Management Information and Data Systems

Support is provided for establishment of a Laboratory for development of Health Information Systems to supply the practicing physician with information of a kind and quality not presently available to him. The practicing physician will define the descriptors which describe his current patient and a search of the data bank will supply him with information on the patients who have these same descriptors and will give a picture of their outcome.

A grant was awarded for the development of a Computerized National Chronic Disease Databank System with the goal of obtaining improved morbidity statistics and increasing available knowledge of the most effective patient regimens through finding and using significant correlates and regimens related to patient outcome.

With National Center support, work is progressing on the construction of a Health Status Index that can be utilized in measurements of the health status of target populations that can, in turn, serve as a guide to determinations relating to health service resource allocations.

Four awards called for data collection and analysis relating to catastrophic illness. One program calls for development of a national profile spelling out the characteristics of catastrophic illness in the United States; a second program involves time-series analyses of catastrophic illness in the nation in order to enhance the preparation of actuarial cost estimates of national catastrophic insurance programs; a third award calls for a targeted study of catastrophic illness addressing spinal injury; and the fourth award is for a targeted study of catastrophic illness addressing myocardial infarction.

A contract entitled "Alternative Working Models for Medical Direction in Skilled Nursing Facilities" was designed to assess the first year compliance with the new standards relative to medical direction in nursing homes and to develop descriptive models of the various working arrangements for medical direction in skilled nursing facilities.

Grants were awarded to the American Nursing Home Association and American Association of Homes for the Aging for a cooperative study of a Cost Data Reporting System for Nursing Homes. The primary focus is the development of a system for analyzing the costs of long-term care according to patient characteristics and service departments in order to provide a sound basis for decisions by administrators, public policy makers, and purchasers of service.

A grant to evaluate Information and Referral services for the homebound was designed to compare the relative effectiveness of telephone and peer contact information and service brokerage systems in meeting the supportive service needs of homebound dysfunctional persons.

(3) Alternatives in Long-Term Care

"Day Hospital Service Rehabilitation Medicine" is an innovative program conducted by Albert Einstein College of Medicine in New York City, Bronx, New York. This 3-year study is designed to determine the feasibility of operating a day hospital service in the Department of Rehabilitation Medicine of a large municipal hospital serving a primarily disadvantaged population. The study population is 200 day hospital patients and 200 hospitalized patients, all of whom are seriously disabled adults, eligible for Medicare and Medicaid, residing in the hospital district serviced by the Bronx Municipal Hospital Center. An evaluation will be made of the Day Hospital experiment along with other similar demonstrations under the activities of Section 222 of P.L. 92-603. The overall evaluation will be in addition to the internal evaluation being conducted by the project.

"Alternatives to Institutionalization for the Aged"--Implemented by Colorado Department of Institutions, Denver, Colorado, the primary aim of this project is to improve the quality of life of elderly inpatients in the Fort Logan Mental Health Center through placement in specialized living arrangements (artificial family or boarding home program), as alternatives to institutional care at a cost lower than that of nursing home care or inpatient psychiatric hospitalization. Evaluation of the effectiveness of this program from the standpoint of quality of life and costs is currently underway. This project is in its third and final year and has been joint-funded with Administration on Aging.

A grant entitled "Tri-Age: Coordinated Delivery of Services to the Elderly" is designed to provide a central entry system for persons over 65 years of age, who live in a specific area in central Connecticut, and have health, social, economic needs for long-term care services. These individuals will have their needs assessed by nurse clinicians and be referred to the appropriate agency(s) and be followed during the duration of the project to determine how well the needs were met, and be reassessed at regular intervals to determine emerging needs for care. A determination will be made of the cost effectiveness of the services provided. Specific objectives are to: (1) Reduce per capita expenditures for health care; (2) Increase effectiveness of services; (3) Reduce incidence of institutionalization; (4) Increase number of home services; and (5) Lead to greater integration of human services in central Connecticut. The National Center for Health Services Research funding is to evaluate "Tri-Age", to determine if quality of care is improved, evaluate outcomes and determine cost effectiveness. Reimbursement for services provided in this program are being made through a waiver arrangement under SSA as part of the P.L. 92-603, Section 222 experiments.

A grant to study the effects of medically oriented housing deals with a specific kind of residential care for aged persons who are at risk for long-term institutional care. It is an experiment in which medically-oriented housing is seen as enabling handicapped and disabled people to remain essentially independent in daily living. As such, medically oriented housing is viewed as an alternative to long-term institutional care. The methodology involves impact on residents in the housing facility over a five-year period; development of separate prediction scales for benefits to people for medically-oriented residence, and assessment of what happens to persons who moved from institutional care to the medically-oriented residence.

(4) Systems Design, Development and Analysis

A Model Services Delivery System for the Aging, developed in Mon Valley, Pennsylvania, was designed to demonstrate the systematized delivery of comprehensive health services for the aging. It is based upon the unique data capability of the Mon Valley human services management board developed with support from the National Center for Health Services Research. The program will develop an integrated data profile on the aging within the defined target area and an appropriate mechanism for "tracking". An in-depth analysis of services for the aging, along with a description of utilization patterns and areas of unmet need will also be provided. The program is expected to result in an integrated and responsive, comprehensive long-term care delivery system which can be effectively evaluated in terms of quality of care, increased cost effectiveness, and increased accessibility to care for replication in other communities.

A project, joint-funded with the Administration on Aging, supports establishment of a National Center for Aging and Black Aged to provide a comprehensive program of coordination, communication, information, and consultative services to meet the need for assistance in improving meaningful policies and programs involving aged Blacks. Consultants will include researchers, educators, and scholars on the aged. Through knowledge gained from comprehensive review of research, a sound basis for program planning for Black elderly will be built. Position papers will be produced and disseminated from the knowledge gained. The Center, as an interpreter of the needs of the Black elderly, will be available to provide consultation to agencies and organizations, both public and private, who desire assistance.

A grant has been awarded to measure the effects of an automatic emergency alarm and response system on the psychological and social well-being of elderly persons at risk, including the cost effectiveness of such an intervention. It will be a controlled impact study of elderly persons in public housing, who are severely or multiply handicapped and clinically judged to be physically vulnerable and/or relatively socially isolated. The major outcome measures to be studied for the effects of use of the automatic emergency alarm and response system are as follows: (1) health status; (2) quality of life indicators (morale, social isolation, etc.); (3) institutionalization; (4) time of death; and (5) the costs of both information as well as formal health and welfare maintenance services. Since it is hoped that the intervention will have the potential for providing a new service for large numbers of the elderly and disabled nationwide, this study will develop projections of cost effectiveness, guidelines for the system's operation, and assessment procedures for effective client screening.

IV. SOCIAL AND REHABILITATION SERVICE

A. ASSISTANCE PAYMENTS ADMINISTRATION

Under the maintenance assistance programs, cash payments are made to needy persons for the cost of food, shelter, clothing and other necessary items of daily living.

P.L. 92-603, enacted October 30, 1972, established a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled. The national program became effective as of January 1, 1974, since which time the Social Security Administration has been responsible for making Federal payments to eligible recipients.

Prior to that date, the maintenance assistance program supporting aged persons was old age assistance. Additionally, there were some persons over age 65 who were recipients under the aid to the blind and aid to the permanently and totally disabled programs, plus aged persons in the aid to families with dependent children program. Since January 1, 1974, these programs have continued in effect in Guam, Puerto Rico, and the Virgin Islands, and the Assistance Payments Administration retains responsibility for administering them in these areas.

The number of aged persons and the total Federal share of cash payments for maintenance assistance programs affecting the aged are shown in Table 1 below for fiscal years 1973 through 1977.

Table 1.--Number of aged and Federal share of payments

Fiscal Year	Number of Recipients	($ in thousands) Federal Payments	($ in thousands) Administrative Cost	Average Annual Payment Rate Per Recipient
73 Actual	2,034,689	$1,187,361	$99,791	$583.80
74 Actual 1/	1,959,670	575,427	59,982	576.01
75 Actual 2/	20,189	[illegible],994	1,768	251.02
76 Estimate 2/	21,677	2,088	1,851	253.36
TQ Estimate 2/	22,42[illegible]	530	470	254.72
77 Estimate 2/	[illegible]	2,120	1,880	256.02

1/ Includes one half-year payments and costs for programs affected by P.L. 92-603.

2/ Adult programs in Guam, Puerto Rico, and Virgin Islands only.

B. PUBLIC SERVICES ADMINISTRATION

The Public Services Administration has responsibility for administering the Social Services program authorized under Titles I, IV-A, X, XIV, XVI and XX of the Social Security Act, as amended. Except for Guam, Puerto Rico, and the Virgin Islands, Title XX superseded all of the authorizing Titles cited above as of October 1, 1975.

Under Title XX, grants are made to States for services to eligible individuals based on income or public assistance status. States may choose the services they will provide, as long as each service conforms to at least one of the five goals stated in the Act.

A variety of services directed at assisting needy aged persons to attain or maintain the maximum level of self-care and independence are provided through the Social Services program. Included are such services as day care, foster care, protective services, health related services, homemaker, chore, transportation, and other services that assist elderly persons to remain in their own homes or in community living situations. Services are also offered which facilitate entry into institutional care when needed and to help the individual move out of institutional care whenever possible. In fiscal year 1976 it is estimated that States will expend $318,000,000 Federal dollars under the Social Services program on services to the aged.

C. MEDICAL SERVICES ADMINISTRATION

Title XIX, known as Medicaid, provides Federal matching payments for State expenditures for health care for the poor. In FY 1975, fifty-three States and jurisdictions were participating in Medicaid (Arizona is the only state not participating; however, Arizona plans to begin its Medicaid program on July 1, 1976.

With the federalization of the adult categories on January 1, 1974, under the Supplementary Security Income (SSI) program, States are not in all cases required to provide Medicaid to all adult recipients of cash assistance under Title XVI, as was the case in the past under Titles I, X, XIV, or XVI. Limited Medicaid coverage of SSI cash assistance recipients will apply in States which, in determining Medicaid eligibility, opt to apply any eligibility criteria from the January 1, 1972, medical assistance standard which is more restrictive than the eligibility requirements for the Federal Title XVI program for aged, blind, and disabled individuals. States which retain any eligibility factor(s) from their January 1, 1972, standard which is (are) more restrictive than the Title XVI eligibility factor(s) must deduct a person's medical expenses from his income in determining eligibility. (They are not required to cover Title XVI cash assistance recipients who have higher income or resources, or who otherwise do not meet the January 1972, medical assistance standard.) Fourteen States have restricted Medicaid eligibility of SSI recipients under this option.

Thirty-six States extend Medicaid coverage to all recipients of cash assistance under the SSI program. States also have the option of providing Medicaid coverage to persons receiving a State Supplemental payment, subject to certain limitations. In addition, States may still elect to cover certain medically needy persons who are eligible for help only with their medical bills and who do not receive maintenance payments.

States are required to provide in their Title XIX program: inpatient hospital care, outpatient care, skilled nursing home care for individuals 21 and over, early and periodic screening, diagnosis and treatment services for children under 21, family planning, physicians services, lab and X-ray services and home health services, as well as, by regulation, transportation to medical care where needed. Use of skilled nursing home services, particularly, is primarily by the aged. In addition, States may cover optional services, many of which are of particular concern to the elderly; for example, 49 offer prescribed drugs, 40 cover eyeglasses, 34 finance physical therapy, and 41 pay for prosthetic devices. Additionally, Title XIX in FY 1974 contained several provisions directed solely to those over 65: payment of Medicare premium, copayment and deductible amounts (for cash assistance recipients), and coverage of inpatient hospital services in institutions for mental diseases.

The aged account for a significant portion of Medicaid expenditures. About 38 percent of the $12.6 billion Federal, State and local program dollars was spent on care for the aged in FY 75, and it is estimated that 3 million people over age 65 received Medicaid services. For most of these persons, Medicaid was providing services which supplemented and complemented those provided by Medicare.

D. SRS OFFICE OF PLANNING, RESEARCH, AND EVALUATION

No SRS programs are targeted on the aged population per se, but elderly persons make up a large percentage of the client population in the Medicaid and Social Services programs, particularly in the long-term care area. The evaluation and research activities of SRS, therefore, consider the aged as a significant sub-group of the client population.

The current evaluation activity most significant for the elderly is a project funded jointly with the Administration on Aging and the Health Resources Administration. This project focuses on de-institutionalization and the question of what is appropriate care for impaired persons. Emphasis is on the testing of a methodology to classify functionally the impairment of adult persons requiring long-term care. A major field test of the functional classification system and survey instrument is scheduled to begin shortly in four States.

Another evaluation effort is examining Federal and State standards for nursing home care and their associated costs to the homes. An additional project is analyzing existing accounting systems in the long-term care industry as a guide to States considering the adoption of a uniform chart-of-accounts for long-term care. Uniformity of accounting systems could assist States in comparing facilities to encourage the most effective spending of the Medicaid dollar on long-term care patients.

A nearly-completed study of the "spend-down" provision of the Medicaid program has obtained data on the socio-demographic and economic characteristics of persons who entered the program through the spend-down mechanisim, including the effects of the spend-down on their income and assets, and the health service requirements which caused them to enter the program. Among the study findings were the determinations that a high proportion of individuals who entered Medicaid via spend-down were aged and that the average spend-down individual spent over $1,000 in medical expenses in the year preceding his/her Medicaid application. Spend-down is definitely a provision that helps the aged who are poor and have unusual medical expenses.

Two FY '76 evaluation projects will also study means to improve the mechanism for becoming eligible for Medicaid. One project will examine the administrative link between the Supplemental Security Income program and Medicaid eligibility, while the other project will determine means to facilitate the implementation of new Medicaid policies.

The Office of Research and Demonstrations within SRS has created a separate identifiable unit in the Health Services Division to focus on long-term care. Analysis of long-term care financing, developing alternatives to institutionalization, and studying the impact upon health delivery systems of a series of alternatives, including non-medical services, is being emphasized.

Although the long-term care R&D program is primarily concerned with the delivery of health care and other appropriate services to the chronically ill and disabled of all age groups, the elderly comprise the highest proportion of the population in need of these services. Promoting community care alternatives to institutionalization for the chronically ill and disabled interested in and able to function outside of institutions can have an important effect upon the lives of the elderly.

During Fiscal '75, two demonstrations and analyses of community-wide coordinated health and social service delivery programs were initiated. The major thrust of this effort is to determine whether integrating services on a community-wide base can improve the quality of care and reduce costs for delivering long-term care to the chronically ill and disabled. The projects are in early planning stages. One, in the State of New York, entitled "Demonstration of Community-Wide Alternative Long-Term Care Models," is testing the feasibility of developing community-wide, population based models for the organization, delivery, and financing of care within Monroe County, New York. The second project, in the State of Washington, "Community-Based Care Systems for the Functionally Disabled - A Project in Independent Living," is an effort to examine the effects of focusing State social services on co-ordinating health and social service delivery in order to prevent unnecessary institutionalization and improve the quality of care for high-risk populations. Each of these projects is an attempt to provide care plans for the populations-at-risk which contribute to the maintenance of integrity and self-sufficiency through appropriate services and placements fitting the functional capacity of the long-term care population. Each will attempt to develop a link to the continuum of care important for this population as well as links with service providers for care delivery. In each of the projects, costs will be tracked and evaluation of effectiveness undertaken through comparison with a control community.

A research project primarily concerned with exploring the viability and cost-effectiveness of delivering services to the chronically ill and disabled in settings other than day care centers, nursing homes, and long-term care hospitals is expected to have several additional products. The project, "The Feasibility and Cost-Effectiveness of Alternative Long-Term Care Settings," is being undertaken by the Stanford Research Institute. Its products, when completed, should provide a number of case studies on long-term care programs outside of nursing homes and long-term care hospitals. (A companion investigation of day care centers has been undertaken by the Health Resources Administration.) A comparison of costs for participants of like functional capacity in nursing homes and the studied settings within the same geographic area will provide insights into the relative costs for different service packages for such groups. These case studies may provide guidelines on initiating similar programs useful to innovators developing community care projects. In addition, a bibliography on studies of long-term care providing systematic information on developments in this field and a report on the effects of legislative, regulatory and/or administrative programs on the feasibility of establishing alternative long-term care programs are being prepared.

The Utah Long-Term Care Payments System project is a State-wide experiment designed to link reasonable cost-reimbursement with the quality of care within skilled nursing facilities. It is not only designed to respond to the requirements of Section 249 of P.L. 92-603 but to add to the system a structure which will increase nursing home accountability for appropriate services to the patients as well as providing an opportunity for the type and level of care extended to individual patients to be a component in the cost-reimbursement system.

Current plans for Fiscal '76 include continued exploration of community-wide coordinated health and social service delivery programs with an additional project which will attempt to demonstrate that more appropriate care may be delivered to recipients of long-term care services at equal or lesser cost through the organization of a centrally managed system of integrated health and social services operated through a client oriented case management process. In addition, a contract with Abt Associates, entitled, "Methodology for Finding, Classifying, and Comparing Costs for Services in Long-Term Care Settings" has been undertaken. This is an effort to develop a structure useful for (1) comparing costs and services by patient characteristics and (2) comparing these costs and services across the spectrum of long-term care alternatives. The methodology, if refined, should be applicable for use by local communities or public interest groups, regional health planning centers, and State agencies in examining current services and planning services appropriate to community needs.

The demonstration projects program in public assistance under Section 1115 of the Social Security Act provides grants for several projects which are totally or partially concerned with providing a variety of services to elderly recipients in public welfare. These projects are carried out under the auspices of State public welfare agencies.

A project in Pennsylvania on health services is demonstrating how such services should be administered to persons 65 years or older who were victims of a flood disaster.

In Connecticut, California, Texas and Wisconsin, projects are demonstrating the effect of social services including day care and homemaker to keep the elderly in their own homes instead of in intermediate care facilities and nursing homes.

Housing allowances are being made to the elderly in eight experiments which are being carried out by the Department of Housing and Urban Development. Waiver of plan requirements have been granted by the Secretary to enable SSI recipients to participate in the experiments without having their grant entitlement reduced.

A project in Alaska permits the exclusion from income for the purpose of determining supplemental security income (SSI) eligibility of monthly benefits which are paid by the State of Alaska to elderly people who have lived there more than 25 years.

A project in North Dakota, which includes the aged, is demonstrating methods of doing medical inspections in standard nursing facilities and independent care facilities.

Other projects involve aged welfare recipients in pre-paid health insurance plans, health maintenance organizations and integrated services delivery centers also involve aged welfare recipients.

(Dollars in Thousands)

	1974 Actual	1975 Actual	1976 Estimate	7/1/76 to 9/30/76 Transition Period Estimate	1977 Estimate
Section 1115 Demonstrations	138	1,298	5,325	125	5,300
Section 1110 Research and Evaluation	422	140	589	80	550

V. OFFICE OF EDUCATION

1. LIBRARY RESOURCES

The Division of Library programs, under the provisions of Title I of the Library Services and Construction Act, provides information and advice on programs oriented to the aging which are administered by State Library agencies; assists training institutions through programs designed to give librarians skills required to meet the special library needs of older persons; maintains liaison with other Federal, State, and local agencies and organizations concerned with the aging; and assists in conferences of professional and lay leaders interested in library-sponsored activities for older people.

Older Americans account for well over half of the almost 400,000 readers of talking books on discs and cassette tapes, braille books and periodicals, and other special materials available free for those unable to use conventional print materials because of physical disability. LSCA funds continue to be utilized in programs to identify eligible readers; publicize available services, purchase materials and reading aids; underwrite programs for taping materials in Spanish, Indian and other non-English languages as well as in English; and provide staff and equipment in regional and sub-regional libraries for the blind and physically handicapped.

Library services especially tailored for the Aging fall into two general categories: those which are provided for the elderly population in institutions; and those which reach out to the elderly in the community.

Since 1967, LSCA has furnished funds for the purpose of establishing and improving library service in institutions operated or substantially supported by a State. The many aged persons residing in State institutions are among the beneficiaries of this program which provides multi-media materials with comfortable, attractive reading, listening and film-viewing facilities. Such libraries offer a variety of programs which may include facilities Such libraries offer a variety of programs which may include films, music, poetry reading, storytelling, book talk, discussions and games.

To isolated, elderly persons who are housebound and to those immobilized in nursing homes, the librarian brings selected materials for reading, viewing, and listening as well as a personal link with the library. In Florida, the Manatee County Library System reaches out to the housebound and to the residents of five nursing homes with Project Score (Senior Citizen-Oriented Reading Effort) with personal visits and the loan of large print books, recordings, and framed color prints. In one year, one staff member recorded 899 visits in this project.

In Boone, Iowa, the Erikson Public Library planned a program and named it "Old Settler's Library," for 2,500 senior citizens living in the oldest section of the city together with 1,800 people receiving public assistance. A rented store front building has become a library center with a special array of print and non-print materials, including cassettes and magazines in large print. It is also used as a senior citizen center, for meetings, socializing, and for assistance to those who want to study independently, gain high school equivalency accreditation, learn a craft, or train for a job, with the help of community college staff and volunteer groups. All age groups are welcomed in "Old Settler's Library," especially those users from the three homes for the aging in the neighborhood.

In 1975 isolated and rural as well as immobilized elderly persons benefited from the increase of books-by-mail programs, provided by libraries at no cost to the users who select their reading from mailed book catalogs.

It is estimated that approximately $600,000 will be used in fiscal year 1976 for projects involving the aging. In fiscal year 1977 Federal support for library services for the elderly will be decreased and it is anticipated that these services will be assumed by States and localities.

2. ADULT EDUCATION

The adult education program authorized under the Adult Education Act of 1966, as amended, provides undereducated adults (persons 16 years of age and older) an opportunity to continue their education to at least the level of completion of secondary school and makes available the means to secure training that will enable them to become more employable, productive, and responsible citizens.

The program is a State grant operation administered by State education agencies according to State plans submitted to the U.S. Office of Education and approved by the U.S. Commissioner of Education. States are allowed grants to pay the Federal share of the cost of establishing or expanding adult education programs in local educational agencies and private non-profit agencies. The matching requirement for the State grant program is 90 percent Federal funds and 10 percent State and/or local funds.

Initial feedback indicates the following age distribution of participants in the adult education program during 1975. The number of participants is expected to remain stable through 1976.

Age Group	Estimate
16 to 24	262,500
25 to 34	202,500
35 to 44	135,000
45 to 54	90,000
55 to 64	37,500
65 to over.................	22,500
Total.................	750,000

Public Law 93-29 amended the Adult Education Act by authorizing the Commissioner to make grants to State and local educational agencies or other public or private nonprofit agencies for programs to further the purpose of this Act by providing educational programs for elderly persons whose ability to speak and read the English language is limited and who live in an area with a culture different than their own. Such programs shall be designed to equip such elderly persons to deal successfully with the practical problems in their everyday life, including the making of purchases, meeting their transportation and housing needs, and complying with governmental requirements such as those for obtaining citizenship, public assistance and social security benefits, and housing. However, to date no appropriations have been made to implement this section.

The Community Schools program, authorized under Part IV, Section 405 of the Education Amendments of 1974, provides grants to States and local educational agencies for programs to stimulate further community education through awards for educational, cultural, recreational and other related community needs. Additional awards are made to institutions of higher education to encourage the training of persons to plan and operate community education programs.

Fiscal year 1976 will be the initial funding year for this program and in order for any community to receive Federal funding, its program must have several minimum elements, including the potential to serve all age groups in the community, including the elderly.

The Consumer Education program, authorized under Part IV of the Education Amendments of 1974, provides funds to stimulate in both school environments and community settings new approaches to consumers' education efforts through competitive contracts and grants. These awards will be used for research, demonstration, pilot projects, training, and the development and dissemination of information on curricula. In addition, funds may be used to demonstrate, test, and evaluate these and other consumers' education activities as well.

Fiscal year 1976 will be the initial funding year for this program and the Office of Education has placed one of its priorities for funding on projects addressing the consumer education needs of the elderly.

3. UNIVERSITY COMMUNITY SERVICE AND CONTINUING EDUCATION

Title I of the Higher Education Act of 1965 authorizes grants to the 50 States, the District of Columbia, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Virgin Islands. The purpose of the program is to facilitate community problem solving through cooperation with postsecondary institutions. Each State administers the program by an agency designated by the Governor, under a State Plan approved by the U.S. Commissioner of Education. The State agency establishes program priorities and approves and funds institutional proposals. Funds are provided by a State formula with a 66-2/3 Federal and 33-1/3 non-Federal basis. Of the sums appropriated the Commissioner may reserve 10 percent for special project discretionary grants, and allot $25,000 each to Guam, American Samoa, Puerto Rico, and the Virgin Islands and $100,000 to each of the States and the District of Columbia. The remainder is distributed on a population ratio basis. Total appropriations for fiscal year 1975 was $14,250,000. No funds have been released for this program in fiscal year 1976 and none are requested for fiscal year 1977.

The State-Grant Program has supported a number of projects designed to assist the older American. During 1975 over 150,000 persons in 32 States participated in 75 such projects. Activities included training programs for professional and paraprofessional staff of nursing homes, preretirement and retirement counseling; consumer education; and informational programs regarding Medicare/Medicaid benefits; legal aid, and housing assistance.

Special Projects authorized by Section 106, permits the Commissioner to reserve 10 percent of funds appropriated in order to support special projects which are designed to seek solutions to regional and national problems brought about by technological change. Such special projects are limited to demonstration or experimental efforts. Projects must be based on a design for and the implementation of organized continuing education activity for adults. In 1975 two projects for the Aging received support at a total cost of $166,352:

1. An award of $114,852 was made to Maricopa County Community College District in Arizona for the project, Six Dimensions for People over Sixty. The project will target services to senior adults. Each college will develop and operate separate program focusing on a different part of the senior adult population and its continuing education needs. Individual projects will use the mass media and direct instructional approaches.

2. $51,500 was directed to the University of Tennessee (Nashville) for Development of an Institutional Model for Community Service and Continuing Education for the Elderly in which ways to increase higher education access for the elderly will be developed and tested. A consortium of four institutions in Tennessee (Dyersburg State Community College, East Tennessee State University, Tennessee Technical University, and the University of Tennessee) will conduct the project.

LIST OF WITNESSES

	Page
Kurzman, Stephen	1
Mathews, Hon. F. D	1
Miller, Charles	1
Young, J. D	1

INDEX

Secretary of Health, Education, and Welfare, testimony of 1-233
- Budget for fiscal year 1977:
  - Amount considered by subcommittee 44
  - Compared with Defense budget 178
  - Controllability of 221
  - Development of 177
  - Funds budgeted for proposed legislation 30
  - Funds budgeted to remain available beyond 1977 31
  - Size of 3, 44
  - Unauthorized budgeted items 25
- Busing 157, 226
- Congressional action on budget 204
- Control of Department by Secretary 199
- Education programs 8
  - "Back to basics" program 224
  - Basic educational opportunity grant program 230
  - Bilingual 231
  - Block grants 46, 229
  - Career education 224
  - Criminal sanctions for student aid abuse 194
  - Cutback in 45, 229
  - Disadvantaged, grants to 229
  - Education for the handicapped 8
  - Educational research, National Institute of Education 9
  - Educational TV 216
  - Elementary and secondary education 8
  - Emergency school aid 8
  - Financial problem of private colleges 223
  - Follow Through program 225
  - Handicapped, increase in funds for 227
  - Higher education 9, 47, 211
    - Indirect cost regulations 48
  - Impact aid 8, 181, 228
  - Increase in programs 226
  - Medical education 206
  - National Institute of Education 224
  - Programs emphasis 226
  - Quality of high school education 226
  - Reading is fundamental program 216
  - Student assistance 202
    - Aid and training programs 229
    - Direct loans 229
    - Loan defaults 220
  - Supplemental grants 231
  - Teacher Corps 225
  - Veterans programs 223
  - Vocational education 224
  - Work study 224, 232
- Employment 11, 180
  - Permanent 13, 22
  - Social and Rehabilitation Service 21

Page

- Federal budget:
  - Controllability of 170
  - Priorities of 205
- Fraud and abuse 182
- General provisions of bill 153
- Grants and contracts 196
- Grants, block 3, 46, 164, 169, 200, 208, 209
- Handicapped, institutionalization of 225
- Health programs:
  - Alcoholism, drug abuse, and mental health administration 6
  - Biomedical research 6
  - Block grants 164, 232
  - Catastrophic health insurance 221
  - Cutback in 45
  - Foreign trained doctors 169
  - Health professions education 6
  - Health services 4
  - Laboratory improvement 6
  - Manpower shortage 220
  - Manpower, supply versus maldistribution 165
  - Maximum allowable cost program 166, 198, 231
  - Medicaid abuses 194
  - Medicaid cost control 174
  - Medicare changes 228
  - Medicare cost sharing 233
  - National health insurance 216
  - National Health Service Corps 4
  - National Institutes of Health:
    - Cuts in 232
    - Disparity among 215
    - Morale of 220
    - National Cancer Institute 228
  - National Institute of Occupational Safety and Health:
    - Location of 157
    - Recruitment of personnel 161
    - Staffing 215
  - Nursing assistance 201
  - Occupational health 5
  - Penalties as program sanctions, use of 171
  - Preventive health 5
  - Professional standards review organizations 7
  - Public Health Service beneficiaries 221
  - Public Health Service hospitals, closing of 5, 164, 210
  - St. Elizabeths Hospital 7
- Internal manpower management 181
- Labor relations 225
- Legislation proposed 3
- Office of Civil Rights 194
- Office of the Secretary staff 195
- Organization of Department 185
- Problems in administering programs 180
- Revenue sharing 207
- Revolving funds 199
- Social security 9
  - Financial integrity 215
  - Supplemental security income 197
- State contributions by programs 215
- Summary tables 12
- Termination of programs 216
- Transition quarter, operations in 227
- Veto of 1976 bill, overriding of 44

Page

Welfare programs:

  - Aid to dependent children error rate 212
  - Enforcement of absent parent support 173
  - Human development 10
  - Office of Investigations 175, 183, 213
    - Public assistance 10
  - Quality control of income assistance programs 174
  - Reform of 172
- Withholding by States of Federal funds going to communities 188

Special reports 233
- Alcoholism 234
- American Indians 291
- Cerebral palsy 324
- Day care 334
- Drug abuse 348
- Family planning 369
- Hearing and speech 424
- Juvenile delinquency 480
- Mental retardation 500
- Migrants 563
- Multiple sclerosis 575
- Muscular dystrophy 586
- Nursing homes 599
- Older Americans 616